

**Acronyms Used:**

AIU – Adopt, Implement, Upgrade

CEHRT – certified EHR Technology (system)

EH – Eligible Hospital

EHR – Electronic Health Records

EP – Eligible Professional

MU – Meaningful Use

March 31st has come and Gone!

The deadline for Incentive Year 2013 attestations has come and gone. As you would expect, we were inundated with attestations that last week, right up to 11:59 PM the 31st. If TennCare received your attestation prior to the deadline, even if we return it because there is a problem, you **have met** the submission requirements. If we returned your attestation due to an eligibility problem or a problem with your MU data, please correct and resubmit as soon as possible. CMS will require us to close the books on 2013 in the next few months.

Attestations received that were not timely submitted will be returned unprocessed.

✘ Corrections for Outstanding 2013 Attestations Needed Soon ✘

If you did meet the March 31 deadline for submitting your 2013 attestation, and your attestation was returned to you for correction, please be diligent in resolving outstanding issues and resubmit as soon as possible. Information regarding what to correct is in the return letter accompanying your returned attestation, or occasionally in an email message sent just prior to the attestation's return.

Not sure if your 2013 attestation was returned? You can check its status in the PIPP Portal. If you see

"AttestationPendingR" as the status, the attestation is "in your court," awaiting your correction or resolution. Opening your attestation will reveal a short "Action" description of the reason(s) for return. If you are in need of more explanation, first check your email for a return letter from "TennCare EHR Incentive" or from "EHR Meaningful Use TennCare". If you do not see such an email message (even after checking your spam folder), it is likely you do not have your current contact email address entered into CMS Registration. Remember to update CMS Registration any time your contact information changes so that we can always communicate with you when necessary.

If your email address is correct, you can contact the appropriate email address found at the end of this newsletter for assistance.

Keep in mind the longer it takes you to complete the process, the longer it will be before TennCare can determine your eligibility for an EHR Incentive Payment.

So, what's up next?



2014 Incentive Year Attestations



Where to start? There are so many changes that have taken effect on January 1. These are the result of the *Final Rule* dated September 4, 2012, and have a wide ranging impact on this year's (and future) attestations. Additionally, for those of you who are both Medicare AND Medicaid providers, you must be certified as Meaningful Users in order to avoid the planned Medicare payment reductions scheduled to begin January 1, 2015. **Please keep in mind**, the payment reductions impact only **Medicare payments**. There **are not** any payment reductions in the Medicaid program, related to the EHR Incentive Program, neither planned nor anticipated. See the chart later in this newsletter about when you must be a meaningful user.

When can I attest for 2014?

CMS has informed the states that whether a provider is attesting for AIU or MU, that provider **MUST** have a 2014-certified EHR system. Further, as a result of the requirements for certified EHR systems (discussed below), CMS has determined that all providers, regardless of what stage of attestation they are in, may use a 90-day period of MU data when attesting.

What does this mean in terms of when you can attest? Obviously, anyone attesting for AIU could attest beginning January 1, 2014. If you are attesting for *any* stage of MU, you are only required to have 90 days of MU data in order to attest. This means if you were using your CEHRT in a meaningful way on January 1, the earliest you could attest was April 1, 2014. Ahh, but there is a catch. See below.

What about your certified EHR system (CEHRT)?

Per the 2012 *Final Rule*, in order to attest for Incentive Year 2014, your CEHRT must meet the 2014 Office of National Coordinator (ONC) standards. These are found in the *Code of Federal Regulations* at 45 CFR § 170. How will you know if your CEHRT meets these requirements? Your vendor should supply you with a NEW CMS Certification Number which will look like this: A0**14E**01CFES9EAB. Regardless of the other digits, the third, fourth, and fifth digits **must be '14E.'** If we do not see '14E', we will return your attestation, using the return reason "Unable to ID EHR System."

On the TennCare Medicaid PIPP portal, the CMS Certification will be preprinted with your previous CMS Certification Number. This is an editable field. You will be able to change this number when you do your attestation. **IMPORTANT:** Be extra careful that you enter your CMS Certification Number **exactly**. CMS requires that we verify your CEHRT, and if we cannot, we will return the attestation to you. We will use the same reason as described above "Unable to ID EHR System."

Above, we mentioned a "catch." The catch is this, your vendor may not have its CEHRT 2014 certified until sometime in 2014. It all depends on when the vendors submitted their systems for review, if they encountered any problems with the review of the system, and the work load for the reviewing agencies. This is one of the reasons, if not the main

one, why CMS is allowing providers to attest with 90 days of MU data rather than a full year's worth.

EHR Documentation Requirements

The EHR documentation requirements **have changed** since the beginning of the program in 2011. We previously informed you of these changes in November 2013. One thing that **has not changed** is that providers are required to submit

documentation for **EACH** year in which they attest. It is not necessary to submit new documentation each year, if the documentation you used previously meets the requirements. With the new 2014 certification standards, we expect to see lots of update information.

The following requirements appear on the EHR Questions screen in the PIPP portal and are in the email we use when we return attestations where documentation requirements are not met.

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. The following list is acceptable documentation of a legal and/or financial 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 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 the 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**

As stated earlier, we are required by CMS to verify your CEHRT. If we cannot, we will return your attestation, giving you the chance to supply appropriate documentation. Additionally, if chosen at random for an audit, you will be required to supply your documentation at that time.

We have heard that vendors have told providers that we don't need this information, that what they were using previously is sufficient, and that we don't know what we are talking about. (Better judgment keeps me from saying what I want to say in response.) *If appropriate documentation is not present with your attestation, we have no choice but to return your attestation to you.* CMS audits us just as they (and we) audit you. If the requirements

are not met, CMS can order TennCare to recoup the EHR Incentive payment.

Medicare Payment Reductions

Are you a Medicare Eligible Professional attesting to the TennCare Medicaid EHR Provider Incentive Program? Please read this Important Information about Medicare Payment Adjustments & Hardship Exceptions for Eligible Professionals

As part of the American Recovery and Reinvestment Act of 2009 (ARRA), Congress mandated payment adjustments to be applied to the **MEDICARE** eligible professionals who are not meaningful users of CEHRT under the Medicare or Medicaid EHR Programs. These payment adjustments will be applied beginning on January 1, 2015, for **Medicare** providers. The payment adjustment will be 1% per year and is cumulative for every year that a Medicare-eligible professional is not a meaningful user. Depending on the total number of Medicare-eligible professionals who are meaningful users under the EHR Incentive Program after 2018, the maximum cumulative payment adjustment can reach as high as 5%. **Medicaid-eligible professionals who only participate in the Medicaid EHR Incentive Program and do not bill Medicare are not subject to these payment adjustments.** Medicare-eligible professionals who are not meaningful users will be subject to a payment adjustment on January 1, 2015.

*Eligible professionals who can participate in the Medicare or Medicaid EHR Incentive Programs will be subject to the **Medicare** payment adjustments unless they are meaningful users under one of the EHR Incentive Programs in the time periods specified below.*

TennCare encourages all EPs who might be affected by the Medicare payment adjustments to attest to meaningful use as early as possible each

payment year to allow sufficient time for evaluation questions and issues to be resolved. If you plan to attest to meaningful use for the first time in 2014, you must submit your attestation prior to October 1, 2014 as stated below.

If you plan to achieve meaningful use for the first time in payment year 2014 read the [important information](#) below about [Meaningful Use reporting deadlines](#):

Medicare-eligible professionals who first demonstrate MU in 2014 must demonstrate MU for a 90 day reporting period in 2014 to avoid the payment adjustment in 2015. ***This reporting period must occur in the first 9 months of the calendar year 2014, and these eligible professionals must attest to MU prior to October 1, 2014, in order to avoid the payment adjustments.*** These EPs must continue to demonstrate MU every year to avoid payment adjustments in subsequent years. For more information, click on this link http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf

If you achieved meaningful use for the first time in payment year 2013

Medicare-eligible professionals who first demonstrate MU in 2013 must demonstrate MU for a 90 day reporting period in 2013 to avoid the payment adjustment in 2015. They must continue to demonstrate MU every year to avoid payment adjustments in subsequent years. For more information, click on this link http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf

If you achieve meaningful use in payment year 2011 or 2012:

Medicare eligible professionals who first demonstrated MU in 2011 or 2012 must

demonstrate MU for a full year in 2013 to avoid the payment adjustments in 2015. These EPs must continue to demonstrate MU every year to avoid payment adjustments in subsequent years. For more information click on this link http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf

Eligible professionals may apply for hardship exceptions to avoid the payment adjustments describe above. Applications for Hardship Exceptions for payment year 2013 are due to CMS by July 1, 2014.

Hardship exceptions will be granted only under specific circumstances and only if CMS determines that provider have demonstrated that those circumstances pose a significant barrier to their achieving meaningful use. **TennCare and other Medicaid programs do not grant hardship exceptions.** These applications must be made directly to Medicare.

For more information about payment adjustments and hardship exceptions follow the CMS link below.

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf

[Eligible professionals](#)

[Eligible professionals submitting multiple National Provider Identifiers \(NPIs\)](#)

The following information about **Medicare EP** payment reductions comes from a CMS EHR Newsletter dated December 17, 2013.

Eligible professionals (EPs) participating in the Medicare EHR Incentive Program may be subject to payment adjustments beginning on **January 1, 2015**. CMS will determine the payment adjustment based on meaningful use data submitted prior to the 2015 calendar year. EPs must demonstrate meaningful use prior to 2015 to avoid payment adjustments.

Determine how your EHR Incentive Program participation start year will affect the 2015 payment adjustments:

If you began in 2011 or 2012...

If you first demonstrated meaningful use in 2011 or 2012, you must demonstrate meaningful use for a full year in 2013 to avoid the payment adjustment in 2015.

If you began in 2013...

If you first demonstrate meaningful use in 2013, you must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid the payment adjustment in 2015.

If you plan to begin in 2014...

If you first demonstrate meaningful use in 2014, you must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid the payment adjustment in 2015. This reporting period must occur in the first 9 months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, to avoid the payment adjustment.

Avoiding Payment Adjustments in the Future

You must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you **MUST** demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.*

If you are only eligible to participate in the Medicaid EHR Incentive Program, you are not subject to these payment adjustments.*

Helpful Resources

For more information on EP payment adjustments, view the [Payment Adjustments and Hardship Exceptions Tipsheet](#) for EPs.

*Emphasis added by TennCare

CMS requires the states to provide information about a provider's MU status on October 1, 2014. If you are attesting to MU for the first time in 2014, we highly encourage providers to attest at the earliest possible date (meaning prior to October 1).

[CMS EHR Incentive](#) web site for the latest information.

Meaningful Use Beyond Stage 2

Eligible Hospitals (EH)

The following paragraph comes from another CMS EHR Newsletter concerning the EH Medicare payment reductions. These reductions begin with the 2015 FFY (October 1, 2014).

[EH] Payment Adjustments

Payment adjustments will be applied beginning FY 2015 (October 1, 2014) to Medicare eligible hospitals that have not successfully demonstrated meaningful use. The adjustment is determined by the hospital's reporting period in a prior year. Read the eligible hospital [payment adjustment tipsheet](#) to learn more.

Questions about the Medicare Payment Reductions for not meeting MU requirements are to be directed to CMS. The CMS Help Desk can be reached at 1-888-734-6433. You can also go to the

Since the ARRA (which included the creation of the Medicare and Medicaid EHR Incentive Programs) was signed into law, the nation has seen unprecedented growth in the adoption and meaningful use of CEHRT. Per the CMS EHR web site, between 2009 and 2012, CEHRT adoption nearly doubled among physicians and more than tripled among hospitals. Every month, thousands of providers join the ranks of hospitals and professionals that have adopted or are meaningfully using EHRs. As of October 2013, CMS estimates 85 percent of EHs and more than 6 in 10 EPs had received a Medicare or Medicaid EHR incentive payment. Moreover, 9 in 10 EHs and 8 in 10 EPs had taken the initial step of registering for the Medicare or Medicaid EHR Incentive Programs as of October 2013. In Tennessee, more than 3,200 EPs and more than 100 EHs have earned a Medicaid EHR incentive payment. Of those EPs earning payments, over 760

are meaningfully using EHRs. Of those EHs earning payments, over 70 are meaningfully using EHRs. Below is important information about the future efforts toward progressing beyond Stage 2 and the updating of EHRs to meet the future challenges.

The CMS has proposed a new timeline for the implementation of MU for the Medicare and Medicaid EHR Incentive Programs, and the Office of the National Coordinator for Health Information Technology (ONC) proposed a more regular approach to update ONC's certification regulations beyond 2014.

Under the revised timeline, Stage 2 will be extended through 2016 and Stage 3 will begin in 2017 for those providers that have completed at least two years in Stage 2. The goal of this change is two-fold: first, to allow CMS and ONC to focus efforts on the successful implementation of the enhanced patient engagement, interoperability and health information exchange requirements in Stage 2; and second, to utilize data from Stage 2 participation to inform policy decisions for Stage 3.

This new proposed timeline tracks ongoing conversations officials at CMS and ONC have had with providers, consumers, health care associations, EHR developers, and other stakeholders in the health care industry. This timeline allows for enhanced program analysis of Stage 2 data to inform to the improvements in care delivery outcomes in Stage 3.

The proposed timeline for meaningful use has a number of benefits, such as:

- More analysis of feedback from stakeholders on Stage 2 progress and outcomes;
- More available data on Stage 2 adoption and measure calculations – especially on new patient engagement measures and health information exchange objectives;
- More consideration of potential Stage 3 requirements;
- Additional time for preparation for enhanced Stage 3 requirements;
- Ample time for developers to create and distribute certified EHR technology before Stage 3 begins, and incorporate lessons learned about usability and customization.

CMS is expected to release a notice of proposed rulemaking (NPRM) for Stage 3, and the corresponding ONC NPRM is expected to release the 2017 Edition of the ONC Standards and Certification Criteria in the fall of 2014. These documents will outline further details for this proposed new timeline. The final rule with all requirements for Stage 3 would follow in the first half of 2015. All stakeholder comments will be reviewed and carefully considered before the release of the final rules.

Eligible providers who have completed at least two years of Stage 2 would begin Stage 3 in 2017. CMS currently anticipates that EPs would begin in January 2017, at the start of the calendar year, and eligible hospitals and critical access hospitals would begin in October 2016 at the start of the federal fiscal year.

EHR Certification Criteria

The new regulatory approach to certification that ONC is proposing would allow for EHR certification criteria to be updated more frequently under the ONC HIT Certification Program. This approach is designed to provide public input on policy proposals, enable ONC's certification processes to more quickly adapt to include newer industry standards that can lead to greater interoperability, and add more predictability for EHR technology developers. CMS also anticipates that its new approach would spread the certification requirements out over a longer time period to which EHR technology developers have previously had to react.

The first step under this new approach would be to publish a proposed rule for a 2015 Edition of certification criteria. The intent is for the 2015 Edition certification criteria to improve on the 2014 Edition certification criteria in several ways. ONC expects the 2015 Edition to be responsive to stakeholder feedback; to address issues found in the 2014 Edition; and to reference updated standards and implementation guides that would continue the momentum toward greater interoperability.

ONC is expected to propose that the 2015 Edition would be voluntary in the sense that providers participating in the EHR Incentive Programs would **NOT** have to upgrade to 2015 Edition EHR technology and **NO** EHR technology developer who

has certified its EHR technology to the 2014 Edition would need to recertify its products. Their intention would be for the 2014 Edition to remain the baseline certification criteria edition for meeting the Certified EHR Technology definition.

To keep informed about the progress on EHR adoption, Stage 3 and new EHR certification standards, visit the CMS web site at http://www.cms.gov/eHealth/ListServ_Stage3Implementation.html.

ATTESTATION TIDBITS

- ❖ **W-9s** – are to be fully completed with the appropriate name and tax ID to whom the EHR Incentive Payment is being made.
- ❖ **ACH Form** – EACH line must be completed, including the area about where the Remittance Advices are to be sent (biggest return reason by far).
- ❖ **Signature Page** – A new, recently signed and dated Signature Form is required EACH year. The current form is 2 pages in length.
- ❖ **Nurse Practitioners** – An NP page is required for all NPs. It provides us with information to help assure you are given credit for all encounters to which are entitled.
- ❖ **Physicians Assistants** – A PA page and copy of the FQHC's/RHC's accreditation letter is required of each PA.

All of these forms are available on the Required Forms screen of the Attestation Packet.

Stage 2 Meaningful Use Information Sharing Objectives

EPs participating in Stage 2 MU must meet objectives that require information to be shared with another party. Three of these objectives – Clinical Summary, Patient Electronic Access, and Summary of Care – outline specific data elements needed to meet the objective. While some of the data elements are common between these three objectives, other data elements are individual to each objective. The following is an explanation of what data must be included in order to meet the requirements for those measures.

- Clinical Summary:** A clinical summary of an office visit provides patients and their families with a record of the office visit and specific lab tests, follow-up actions, and treatment related to the visit. While this information is part of the patient's overall electronic health record, the clinical summary highlights information relevant to the patient's care at that particular moment.

Because it is designated to be linked to a particular office visit and provided to the patient either at the conclusion of the visit or shortly thereafter, the information required for the clinical summary is limited to the information that is available in the EHR at the time the clinical summary is provided. If an EP has not yet entered specific data element into the EHR at the time of the clinical summary is provided, that field can be left blank and the EP can still meet the objective. However, if listed information is available in the EHR at the time the clinical summary is provided, it must be included in the clinical summary (except as described below). The clinical summary can be provided either online or on paper. To meet the measure threshold, the EP must provide the clinical summary for more than 50 percent of office visits within one (1) business day. However, the EP may withhold any information from the clinical summary if he or she believes that providing such information may result in significant harm to the patient. All information in the table below and available in the EHR at the time the clinical summary is provided must be part of the clinical summary provided to the patient.

Information Requirements for Clinical Summary Measure	
Patient Name	Laboratory test results
Provider's name and office contact information	List of diagnostic tests pending
Date and location of the visit	Clinical instructions
Reason for the visit	Future appointments
Current problem list	Demographic information maintained within certified EHR technology (sex, race, ethnicity, date of birth, preferred language)
Current medication list	Smoking status
Current medication allergy list	Care plan field(s), including goals and instructions
Procedures performed during the visit	Recommended patient decision aids (if applicable to the visit)
Immunizations or medications administered during the visit	Vital signs taken during the visit (or other recent vital signs)

- Patient Electronic Access:** Online access allows patients easy access to their health information so that they can make informed decisions regarding their care and share their most recent clinical information with other health care providers and personal caregivers. The requirement for patient electronic access is similar to those for clinical summaries. The patient electronic access measure requires EPs to provide patients the ability to view online, download, and transmit their health information within four (4) business days of the information being available to the provider. Unlike clinical summaries, which are tied to a specific office visits, providing patient electronic access to information is an ongoing requirement. If a specific data field is not available to the EP at the time the information is sent to the patient portal, that information does not have to be made available online and the EP can still meet the objective.

However, as new information for the specific items listed below becomes available to the provider, that information must be updated and made available to the patient online within four (4) business days. However, the EP may withhold any information from online disclosure if he or she believes that providing such information may result in significant harm to the patient. In addition, the fields for problem list, medication list, and medication allergy list must either contain problems, medications, and medication allergies or a specific notation that the patient has none. All information in the table below and available at the time the information is sent to the patient portal must be made available to the patient online.

Information Requirements for Patient Electronic Access Measure

Patient Name	Procedures
Provider's name and office contact information	Laboratory test results
Current and past problem list	Current medication list and medication history
Smoking status	Care plan field(s), including goals and instructions
Demographic information (preferred language, sex, race, ethnicity, date of birth)	Vital signs(height, weight, blood pressure, BMI, growth charts)
Any known care team members, including the primary care provider (PCP) of record	
Unless the information is not available in certified EHR technology (CEHRT), is restricted from disclosure due to any federal, state, or local law regarding the privacy of a person's health information, including variations due to the age of the patient, or the provider believes that substantial harm may arise from disclosing particular health information in this manner.	

- Summary of Care:** EPs caring for the same patient who share information with one another can more effectively coordinate the care they provide. The purpose of a summary of care record is to ensure that the provider who transitions a patient to someone else's care gives the receiving provider the most up-to-

date information available. When an EP transitions his/her patient to another setting or provider of care, or refers the patient to another provider, the EP should provide a summary of care record for the next provider of care. Similar to the clinical summary and patient online access objectives, the information

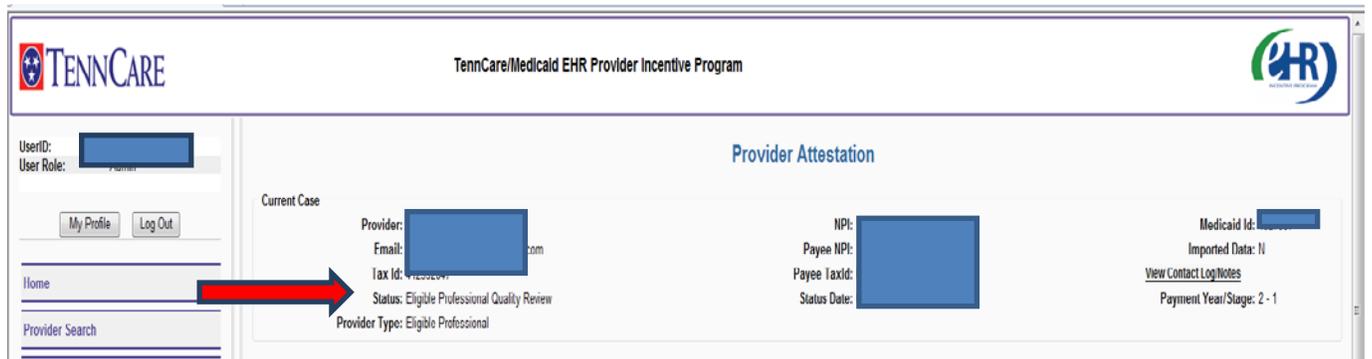
provided as part of the summary of care is generally limited to what is available to the EP and in the certified EHR technology at the time the summary of care is generated. Unlike the clinical summary and patient online access objectives, the EP must verify that information was entered into the EHR for problem list, medication list, and medication allergy list prior to generating the summary of care.

The problem list, medication list and medication allergy list must either contain specific information or a notation that the patient has none of these items. Leaving the field blank would not allow the provider to meet the objective. If other data elements from the list below are not available in the EHR at the time the summary of care is generated, that information does not have to be made available in the summary of care.

Information Requirements for Summary of Care	
Patient Name	Procedures
Encounter diagnosis	Immunizations
Laboratory test results	Vital signs (height, weight, blood pressure, BMI)
Smoking status	Care plan field, including goals and instructions
Reason for referral	Current medication list **
Current medication allergy list **	Current problem list (EPs may also include historical problems at their discretion) **
Referring or transitioning provider's name and office contact information	Functional status, including activities of daily living, cognitive and disability status
Demographic information (preferred language, sex, race, ethnicity, date of birth)	Care team, including the primary care provider of record and any additional known care team members beyond the referring or transitioning provider and the receiving provider
** Required Fields	

PPP Portal Status Codes and Their Meaning

The following chart explains the status codes of your attestation.



CMS Received	TennCare has received your registration information from CMS
Attestation Pending	You have begun, but not completed, the attestation process
Attestation Review	Your attestation has been submitted and TennCare is reviewing the first 4 pages of your attestation
Eligibility Attestation Returned	A problem has been found on one of the first 4 screens of the attestation and your attestation has been returned to you with an explanation
Audit Review	TennCare is verifying your patient encounter patient volume
Audit Review Complete	A problem has been found in your patient encounter volume data; if unable to resolve internally, you are sent an email of explanation
Quality Review	Your MU data is being reviewed
Quality Pending or Meaningful Use Attestation Returned	A problem has been found with your MU data and the attestation has been returned to you with an explanation
Pending CMS Payment Review	TennCare has submitted information to CMS and is awaiting authorization to make payment
Ready for Payment	CMS has responded and approved TennCare's request to make payment
Payment Pending	Information has been sent to the State's payment system
Payment Complete	Payment has been made by TennCare
Attestation Denied	Your attestation failed; an email of explanation has been sent
Payment Rejected by CMS	CMS has denied TennCare's request to make payment; an explanation is sent
Cancelled by CMS	CMS has cancelled the provider's registration



Contact Information

As always, anytime you have a question or need assistance, please feel free to contact us. We will get back to you as quickly as possible.

Please be sure to include the provider's name and NPI when contacting us.

- ◆ For questions relating to **Meaningful Use (MU)**, send an email to EHRMeaningfuluse.TennCare@tn.gov
- ◆ For **all other questions**, send an email to TennCare.EHRIncentive@tn.gov
- ◆ The **CMS Help Desk** can be reached at 1-888-734-6433.
- ◆ **TennCare Medicaid EHR Incentive Program web site:** http://www.tn.gov/tenncare/ehr_intro.shtml
- ◆ **PowerPoint Presentations** on different subject areas are available here: http://www.tn.gov/tenncare/ehr_page6.shtml

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