



# Medicaid EHR Incentive Program

**Adopt, Implement, Upgrade  
Attestation Manual**  
(Formerly Provider User Manual)

December 19, 2016 (Revised)



# Table of Contents

<b>1 INTRODUCTION</b>	<b>4</b>
<b>2 BACKGROUND</b>	<b>5</b>
<b>3 ELIGIBILITY</b>	<b>5</b>
3.1 <i>Out-of-State Providers</i>	8
3.2 <i>Establishing Patient Volume</i>	8
3.2.1 Patient Encounters Methodology for EPs	8
3.2.2 Eligible Professional DMS Encounter Definition	8
3.2.3 Definition of a Needy Individual Encounter	8
3.2.4 Group Practices	9
3.2.5 Patient Encounters Methodology for EHs and CAHs	9
3.2.6 Eligible Hospital DMS Encounter Definition	9
<b>4 PAYMENT METHODOLOGY</b>	<b>10</b>
4.1 <i>Payments</i>	12
<b>5 PROVIDER REGISTRATION</b>	<b>13</b>
<b>6 PROVIDER ATTESTATION PROCESS AND VALIDATION</b>	<b>14</b>
<b>7 INCENTIVE PAYMENTS</b>	<b>15</b>
<b>8 PROGRAM INTEGRITY</b>	<b>16</b>
8.1 <i>Administrative Audits/Appeals</i>	16
<b>9 GETTING STARTED</b>	<b>16</b>
9.1 <i>Sign-in Screen</i>	17
9.2 <i>Home Screen</i>	17
9.3 <i>Registration Data Screen</i>	19
9.4 <i>Provider Eligibility Details Screen</i>	22
9.4.1 Eligibility Details	25
9.4.2 EHR Details	28
9.4.3 Service Locations	28
9.5 <i>Incentive Payment Calculation Screen</i>	30
9.6 <i>Documentation Upload Screen</i>	32
9.7 <i>Attestation Statement Screen</i>	33
9.8 <i>View All Payments Screen</i>	39
9.9 <i>Issues / Concerns Screen</i>	39

<b>10</b>	<b>AUDIT AND APPEALS .....</b>	<b>40</b>
10.1	<i>Attestation Appeals Screen .....</i>	<i>41</i>
10.2	<i>Provider Audit Appeal Screen .....</i>	<i>42</i>
10.3	<i>Audit Appeal Details Screen Appeal Setup Tab .....</i>	<i>42</i>
10.4	<i>Audit Appeal Details Screen Findings Tab .....</i>	<i>44</i>
10.4.1	Audit Appeal Details Screen Appeal Document Upload .....	45
10.4.2	Audit Appeal Details Screen Appeal Outcome Tab .....	45

# 1 INTRODUCTION

The Kentucky Medicaid Electronic Health Record (EHR) Incentive Program provides incentive payments to eligible professionals (EPs), eligible hospitals (EHs) and critical access hospitals (CAHs) as they adopt, implement, upgrade (AIU) or demonstrate meaningful use (MU) of certified EHR technology. The purpose of this document is to provide instructions for providers to register for and complete attestation for the Kentucky Medicaid EHR Incentive Program using the KYSLR system.

## Resources:

- 42 CFR Parts 412, 413, 422 et al. Medicare and Medicaid Programs; Electronic Health Record Incentive Program Final Rule located at <http://www.gpo.gov/fdsys/pkg/FR-2010-07-28/pdf/2010-17207.pdf>
- Kentucky State Medicaid HIT Plan (SMHP) Version 1.0 located at <http://chfs.ky.gov/dms/EHR.htm>
- Kentucky Medicaid EHR Application Portal located at <https://prdweb.chfs.ky.gov/KYSLR/Login.aspx>
- Medicare and Medicaid Electronic Health records (EHR) Incentive Program located at <http://www.cms.gov/EHRIncentivePrograms/>
- Office of the National Coordinator for Health Information Technology located at <http://healthit.gov/>

Regional Extension Centers (RECs) have been designated to provide technical assistance to Kentucky providers. The RECs provide a full range of assistance related to EHR selection and training are listed below:

- Northeast Kentucky Area  
NorthEast Kentucky Regional Information Organization (NeKY RHIO)  
Website: <http://www.nekyrhio.org>  
Phone: 855-385-2089  
E-mail: [admin@nekyrhio.org](mailto:admin@nekyrhio.org)
- Remaining Areas of Kentucky  
Kentucky Regional Extension Center  
Website: <http://kentuckyrec.com>  
Phone: 888-KY-REC-EHR or 859-323-3090  
E-mail: [kyrec@uky.edu](mailto:kyrec@uky.edu)

If you would like more information on the measures required for Meaningful Use please see the site below:

<http://www.cms.gov/EHRIncentivePrograms/>

## 2 BACKGROUND

The Centers for Medicare & Medicaid Services (CMS) has implemented, through provisions of the American Recovery and Reinvestment Act of 2009 (ARRA), incentive payments to EPs, EOs and CAHs, participating in Medicare and Medicaid programs that are meaningful users of certified EHR technology. The incentive payments are not a reimbursement, but are intended to encourage providers to adopt, implement, or upgrade certified EHR technology and use it in a meaningful manner.

Use of certified EHR systems is required to qualify for incentive payments. The Office of the National Coordinator for Health Information Technology (ONC) has issued rules defining certified EHR systems and has identified entities that may certify systems. More information about this process is available at <http://www.healthit.gov>.

Goals for the national program include: 1) enhance care coordination and patient safety; 2) reduce paperwork and improve efficiencies; 3) facilitate electronic information sharing across providers, payers, and state lines and 4) enable data sharing using state Health Information Exchange (HIE) and the National Health Information Network (NHIN). Achieving these goals will improve health outcomes, facilitate access, simplify care and reduce costs of health care nationwide.

The Kentucky Department for Medicaid Services (DMS) works closely with federal and state partners to ensure the Kentucky Medicaid EHR Incentive Program fits into the overall strategic plan for the Kentucky Health Information Exchange (KHIE), thereby advancing national and Kentucky goals for HIE.

Providers are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS' official Web site for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>. The site provides general and detailed information on the programs, including tabs to guide users on the path to payment, eligibility, meaningful use, certified EHR technology, and frequently asked questions.

## 3 ELIGIBILITY

While providers could begin the program in Calendar Year (CY) 2011, they must begin the program no later than CY 2016.

The first tier of provider eligibility for the program is based on provider type and specialty. If the provider type and specialty for the submitting provider in the KY MMIS provider data store **does not** correspond to the provider types and specialties approved for participation in the Kentucky Medicaid EHR Incentive Program, the provider will receive an error message with a

disqualification statement.

At this time, CHFS DMS has determined the following providers are potentially eligible to enroll in the Kentucky Medicaid EHR Incentive Program:

- Physicians = Any provider who has a Provider Type 64 and Specialty other than 345 (Pediatrics)
- Physician Assistants (practicing in a FQHC [Provider Type 31 and Specialty 80] or RHC [Provider Type 35] led by a Physician Assistant) = Any provider with a Provider Type 95 and Specialty other than 959 (PA Group). A FQHC or RHC is considered to be PA led in the following instances:
  - The PA is the primary provider in a clinic (e.g., part time physician and full time PA in the clinic)
  - The PA is the clinical or medical director at a clinical site of the practice
  - The PA is the owner of the RHC
- Pediatricians = Any provider with a Provider Type 64 and Specialty 345
- Nurse Practitioners = Any provider with a Provider Type 78 and not Specialty 095 (CNM) or 789 (Nurse Practitioner Group)
- CNMs = Any provider with a Provider Type 78 and Specialty 095
- Dentists = Any provider with a Provider Type 60 (Individual)
- Optometrists = Any provider with a Provider Type 77
- Acute Care Hospital = Any provider with a Provider Type 01 and Specialty 010
- Children’s Hospital = Any provider with a Provider Type 01 and Specialty 015
- CAH = Any provider with a Provider Type 01 and Specialty 014

### **Additional Requirements for the EP**

To qualify for an EHR incentive payment for each year the EP seeks the incentive payment, the EP must not be hospital-based and must:

1. Meet one of the following patient volume criteria:
  - a. Have a minimum of 30 percent patient volume attributable to individuals receiving TXIX and/or TXXI-CHIP (but not separate CHIPs) Medicaid services; **or**
  - b. Have a minimum 20 percent patient volume attributable to individuals receiving TXIX and/or TXXI-CHIP (but not separate CHIPs) Medicaid services, **and** be a pediatrician; **or**
  - c. Practice predominantly in a FQHC or RHC and have a minimum 30 percent patient volume attributable to needy individuals.
2. Have no sanctions and/or exclusions.

An individual EP may choose to receive the incentive directly or assign it to a Medicaid contracted clinic or group to which the provider is associated. The tax identification number (TIN) of the individual or entity receiving the incentive payment is required when registering with the National

Level Registry (NLR) and must match a TIN linked to the individual provider in DMS’s system. If there is no contract on file with KY Medicaid, the system will not be available to a provider for attestation until a contract has been approved by DMS.

**Note** also that some provider types who are eligible for the Medicare program, such as podiatrists and chiropractors, are not currently eligible for the Kentucky Medicaid EHR Incentive Program. The following Table is a summary of qualifying provider types and minimum patient encounter volumes.

**Qualifying Providers by Type and Patient Volume**

<b>Program Entity</b>	<b>Percent Patient Volume over Minimum 90-days</b>	
Physicians	30%	Or the Medicaid EP practices predominantly in an FQHC or RHC - 30% “needy individual” patient volume threshold
Pediatricians	20%	
Dentists	30%	
Optometrist	30%	
Physician Assistants when practicing at an FQHC/RHC led by a physician assistant	30%	
Nurse Practitioner	30%	

**Additional requirements for the EH/CAH**

To qualify for an EHR incentive payment for each year the EH seeks the incentive payment, the EH must be one of the following:

1. An acute care hospital (includes CAH) that has at least a 10 percent Medicaid patient volume for each year the hospital seeks an EHR incentive payment **or**
2. A children’s hospital (exempt from meeting a patient volume threshold).

Hospital-based providers are not eligible for the EHR incentive program.

**Qualifying Providers by Type and Patient Volume**

<b>Program Entity</b>	<b>Percent Patient Volume over Minimum 90-days</b>
Acute Care Hospital	10%
Children’s Hospital	Patient Encounter definition expanded to include TXXI-CHIP encounters (but not separate CHIPs)

### 3.1 Out-of-State Providers

The Kentucky Medicaid EHR Incentive Program welcomes out-of-state providers to participate in this program as long as they have at least one physical location in Kentucky. Kentucky must be the only state they are requesting an incentive payment from during that participation year. For audit purposes, out-of-state providers must make available any and all records, claims data, and other data pertinent to an audit by either the Kentucky DMS program or CMS. Records must be maintained as applicable by law in the state of practice or Kentucky, whichever is deemed longer.

### 3.2 Establishing Patient Volume

An eligible provider must annually meet patient volume requirements to participate in Kentucky's Medicaid EHR Incentive Program as established through the state's CMS approved State Medicaid Health IT Plan (SMHP). The patient funding source identifies who can be counted in the patient volume: Title XIX (TXIX) – Medicaid and Title XXI (TXXI) – CHIP (but not separate CHIPs). All providers should calculate patient volume based on TXIX - Medicaid and/or TXXI-CHIP and out-of-state Medicaid patients.

#### 3.2.1 Patient Encounters Methodology for EPs

- To calculate TXIX-Medicaid and/or TXXI-CHIP patient volume, an EP must divide:
  - The total TXIX and/or TXXI-CHIP Medicaid or out-of-state Medicaid patient encounters in any representative, continuous 90-day period in the prior calendar year or preceding 12 months from date of attestation; by
  - The total patient encounters in the same 90-day period.
- EPs Practicing Predominantly in an FQHC/RHC – to calculate needy individual patient volume, an EP must divide:
  - The total needy individual patient encounters in any representative, continuous 90-day period in the prior calendar year or preceding 12 months from date of attestation; by
  - The total patient encounters in the same 90-day period.

#### 3.2.2 Eligible Professional DMS Encounter Definition

For purposes of calculating EP patient volume, a DMS encounter is defined as any service rendered on any one day to an individual enrolled in a Medicaid program whether or not Medicaid had a financial interest in the services that were rendered.

#### 3.2.3 Definition of a Needy Individual Encounter

For purposes of calculating patient volume for an EP practicing predominantly in an FQHC/RHC, a needy individual encounter is defined as services rendered on any one day to an individual where medical services were:

- Furnished by the provider as uncompensated care; or
- Furnished at either no cost or reduced cost based on a sliding scale determined by the individual's ability to pay.

### **3.2.4 Group Practices**

Clinics or group practices will be permitted to calculate patient volume at the group practice/clinic level, but only in accordance with all of the following limitations:

- The clinic or group practice's patient volume is appropriate as a patient volume methodology calculation for the EP.
- There is an auditable data source to support the clinic's or group practice's patient volume determination.
- **All** EPs in the group practice or clinic must use the same methodology for the payment year.
- The clinic or group practice uses the entire practice or clinic's patient volume and does not limit patient volume in any way; and if an EP works inside and outside of the clinic or practice, then the patient volume calculation includes only those encounters associated with the clinic or group practice, and not the EP's outside encounters.

### **3.2.5 Patient Encounters Methodology for EHs and CAHs**

To calculate TXIX Medicaid patient volume, an EH must divide:

- The total TXIX Medicaid and out-of-state Medicaid encounters in any representative 90-day period in the prior fiscal year OR the preceding 12 months from the date of attestation by:
  - The total encounters in the same 90-day period.
    - Total number of inpatient bed days for all discharges in a 90-day period (even if some of those days preceded the 90-day range) plus total number of emergency department visits in the same 90-day period. (Please note per CMS FAQ nursery days are excluded from inpatient bed days)
    - An emergency department must be part of the hospital.

### **3.2.6 Eligible Hospital DMS Encounter Definition**

For purposes of calculating eligible hospital patient volume, a DMS encounter is defined as service rendered to an individual enrolled in a Medicaid program whether or not Medicaid had a financial interest in the services that were rendered.

## 4 PAYMENT METHODOLOGY

### For EPs:

The maximum incentive payment an EP could receive from Kentucky Medicaid equals \$63,750, over a period of six years, or \$42,500 for pediatricians with a 20-29 percent DMS patient volume as shown below.

<b>Provider</b>	<b>EP</b>	<b>EP-Pediatrician</b>
<b>Patient Volume</b>	<b>30 percent</b>	<b>20-29 percent</b>
<b>Year 1</b>	\$21,250	\$14,167
<b>Year 2</b>	\$8,500	\$5,667
<b>Year 3</b>	\$8,500	\$5,667
<b>Year 4</b>	\$8,500	\$5,667
<b>Year 5</b>	\$8,500	\$5,667
<b>Year 6</b>	\$8,500	\$5,665
<b>Total Incentive Payment</b>	\$63,750	\$42,500

Since pediatricians are qualified to participate in the Kentucky Medicaid EHR incentive program as physicians, and therefore classified as EPs, they may qualify to receive the full incentive if the pediatrician can demonstrate that they meet the minimum 30 percent Medicaid patient volume requirements.

### For EHs and CAHs:

Statutory parameters placed on Kentucky Medicaid incentive payments to hospitals are largely based on the methodology applied to Medicare incentive payments. The specifications described in this section are limits to which all states must adhere when developing aggregate EHR hospital incentive amounts for Medicaid-eligible hospitals. States will calculate hospital aggregate EHR hospital incentive amounts on the FFY to align with hospitals participating in the Medicare EHR incentive program.

Children’s hospitals and acute care hospitals may be paid up to 100 percent of an aggregate EHR hospital incentive amount provided over a three-year period. Section 1905(t)(5)(D) requires that no payments can be made to hospitals after 2016 unless the provider has been paid a payment in the previous year; thus, while Medicaid EPs are afforded flexibility to receive payments on a non-consecutive, annual basis, hospitals receiving a Medicaid incentive payment must receive payments on a consecutive, annual basis after the year 2016. The aggregate EHR hospital incentive amount is calculated using an overall EHR amount multiplied by the Medicaid share.

Kentucky is responsible for using auditable data sources to calculate Medicaid aggregate EHR hospital incentive amounts, as well as determining Kentucky Medicaid incentive payments to those providers. Auditable data sources include:

- Providers' Medicare cost reports;
- State-specific Medicaid cost reports;
- Payment and utilization information from the Kentucky MMIS (or other automated claims processing systems or information retrieval systems); and
- Hospital financial statements and hospital accounting records.

The Kentucky Medicaid EHR Incentive Program hospital aggregate incentive amount calculation will use the equation outlined in the Final Rule, as follows:

$$\text{EH Payment} = \text{Overall EHR Amount} \times \text{Medicaid Share}$$

Where:

**Overall EHR Amount** = {Sum over 4 year of [(Base Amount plus Discharge Related Amount Applicable for Each Year) times Transition Factor Applicable for Each Year]}

**Medicaid Share** = {(Medicaid inpatient-bed-days + Medicaid managed care inpatient-bed-days) divided by [(total inpatient-bed days) times (estimated total charges minus charity care charges) divided by (estimated total charges)]}

Kentucky intends to pay the aggregate hospital incentive payment amount over a period of three annual payments, contingent on the hospital's annual attestations and registrations for the annual Kentucky Medicaid payments. The reason for this approach is that most of Kentucky's numerous rural hospitals operate on a very thin margin and need the money as soon as possible to offset their EHR system costs.

In the first year, if all conditions for payment are met, 50 percent of the aggregate amount will be paid to the EH. In the second year, if all conditions for payment are met, 40 percent of the aggregate amount will be paid to the EH. In the third year, if all conditions for payment are met, 10 percent of the aggregate amount will be paid to the EH.

Kentucky has worked with CMS on ways to effectively calculate costs. For example, charity care costs are not included on Kentucky's cost report. Kentucky has received approval from CMS to use the Kentucky Medical Assistance Program (KMAP) disproportionate share form data in lieu of cost reports for this data. A standard questionnaire is used to determine the disproportionate share.

To the extent there is simply not sufficient data that would allow us to estimate the inpatient bed-days attributable to Medicaid managed care patients, the statute directs that such figure is deemed to equal 0. Likewise, if there is simply not sufficient data for the state to estimate the percentage of inpatient bed days that are not charity care (that is, [estimated total charges—charity care charges]/estimated total charges), the statute directs that such figure is deemed to equal 1. Unlike Medicaid EPs, who must waive rights to duplicative Medicare incentive payments, hospitals may receive incentive payments from both Medicare and Medicaid,

contingent on successful demonstration of meaningful use and other requirements under both programs.

The last year that a hospital may begin receiving Medicaid incentive payments is FY 2016. Additionally, in any given payment year, no annual Medicaid incentive payment to a hospital may exceed 50 percent of the hospital's aggregate incentive payment. Likewise, over a two-year period, no Medicaid payment to a hospital may exceed 90 percent of the aggregate incentive.

#### **4.1 Payments**

EP payments will be made in alignment with the calendar year and an EP must begin receiving incentive payments no later than CY 2016. EPs will assign the incentive payments to a tax ID (TIN) in the CMS EHR Registration and Attestation National Level Repository (NLR). The TIN must be associated in the Kentucky MMIS system with either the EP him/herself or a group or clinic with whom the EP is affiliated. EPs who assign payment to himself or herself (and not a group or clinic) will be required to provide DMS with updated information. Each EP must have a current DMS contract and be contracted for at least 90 days.

The Kentucky Medicaid EHR Incentive program does **not** include a future reimbursement rate reduction for non-participating Medicaid providers. (**Medicare** requires providers to implement and meaningfully use certified EHR technology by 2015 to avoid a Medicare reimbursement rate reduction.) For each year a provider wishes to receive a Medicaid incentive payment, determination must be made that provider was a meaningful user of EHR technology during that year. Medicaid EPs are not required to participate on a consecutive annual basis. However, the last year an EP may begin receiving payments is 2016, and the last year the EP can receive payments is 2021.

In the event that DMS determines monies have been paid inappropriately, incentive funds will be recouped and refunded to CMS.

The timeline for receiving incentive payments is illustrated below:

	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016
CY 2011	\$21,250					
CY 2012	\$8,500	\$21,250				
CY 2013	\$8,500	\$8,500	\$21,250			
CY 2014	\$8,500	\$8,500	\$8,500	\$21,250		
CY 2015	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250	
CY 2016	\$8,500	\$8,500	\$8,500	\$8,500	\$8,500	\$21,250
CY 2017		\$8,500	\$8,500	\$8,500	\$8,500	\$8,500
CY 2018			\$8,500	\$8,500	\$8,500	\$8,500
CY 2019				\$8,500	\$8,500	\$8,500
CY 2020					\$8,500	\$8,500
CY 2021						\$8,500
TOTAL	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750	\$63,750

EH and CAH payments will be made in alignment with the fiscal year. EHs and CAHs must begin receiving incentive payments no later than FY 2016.

## 5 PROVIDER REGISTRATION

If this is your first year with the EHR Incentive program, providers are required to begin by registering at the national level with the Medicare and Medicaid registration and attestation system (also referred to as the NLR). CMS’ official website for the Medicare and Medicaid EHR Incentive Programs can be found at <http://www.cms.gov/EHRIncentivePrograms/>.

Providers must enter their name, NPI, business address, phone number, taxpayer ID number (TIN) of the entity receiving the payment while EHs and CAHs must also provide their CCN. EPs may choose to receive the incentive payment themselves or re-assign payment to a clinic or group to which they belong.

EPs must choose to participate in either the Medicare or Medicaid’s incentive program. If Medicaid is selected, the provider must choose only one state (EPs may switch states annually). Providers must revisit the NLR to make any changes to their information and/or choices, such as changing the state from which they want to apply for their incentive payment. After the initial registration, the provider does not need to return to the NLR before seeking annual payments **unless** information needs to be updated.

EHs seeking payment from both Medicare and Medicaid will be required to visit the NLR annually to attest to meaningful use before returning to the KYSLR system to attest for Kentucky’s Medicaid EHR Incentive Program. DMS will assume meaningful use is met for

hospitals deemed so for payment from the Medicare EHR Incentive Program.

The NLR will assign the provider a CMS Registration Number and electronically notify DMS of a provider's choice to access Kentucky's Medicaid EHR Incentive Program for payment. The CMS Registration Number is required to complete the attestation in the KYSLR system.

On receipt of NLR Registration transactions from CMS, two basic validations take place at the state level: 1) validate the NPI in the transaction is on file in the MMIS system, and 2) validate the provider is a provider with the Kentucky DMS. If either of these conditions is not met, a message will be automatically sent back to the CMS NLR indicating the provider is not eligible. Providers may check back at the NLR level to determine if the registration has been accepted.

Once payment is disbursed to the provider based on the specified TIN, the NLR will be notified by DMS that a payment has been made.

## 6 PROVIDER ATTESTATION PROCESS AND VALIDATION

DMS uses the secure KYSLR system to house the attestation system. If an eligible provider registers at the NLR and does not receive the link to the attestation system within two business days, assistance is available by contacting the EHR Incentive Program at 502-564-0105 extension 2463.

The following is a brief description of the information that a provider must report or attest to during the process:

1. After registering at the CMS EHR Registration and Attestation National Level Repository (NLR) (at <https://ehrincentives.cms.gov/hitech/login.action>, the provider will receive an email at the email address provided upon registration, indicating they are eligible for the program.
2. The provider will log into the KYSLR using their NPI and CMS-assigned Registration Identifier.
3. The provider is asked to view the information displayed with the pre-populated data received from the NLR.
4. EPs will then enter two categories of data to complete the Eligibility Provider Details screen including: 1) patient volume characteristics, and 2) certification number for the ONC-ATCB certified EHR system (or numbers if obtained in modules.).

The EP will be asked to attest to:

- Assigning the incentive payment to a specific TIN (only asked if applicable); provider and TIN to which the payment is assigned at the NLR will be displayed;
- Not working as a hospital based professional (this will be verified by DMS through claims analysis);
- Not applying for an incentive payment from another state or Medicare;
- Not applying for an incentive payment under another DMS ID; and

- Adoption, implementation, or upgrade of certified EHR technology.

EHR and CAHs must enter three categories of data to complete the Eligibility Provider Details screen including: 1) patient volume characteristics, 2) completed hospital EHR Incentive Payment worksheet and 3) certification number for the ONC-ATCB certified EHR system.

The EHR will be asked to attest to:

- Adoption, implementation or upgrade of certified EHR technology;
  - Not applying for a Medicaid incentive payment from another state
5. The providers are asked to electronically sign the attestation.
- The provider or the agent/ staff member's initials are entered
  - The providers NPI

Once the electronic attestation is submitted by a qualifying provider and appropriate documentation is provided, DMS will conduct a review which will include cross-checking for potential duplication payment requests, checking provider exclusion lists and verifying supporting documentation.

The attestation itself will be electronic and will require the provider to attest to meeting all requirements defined in the federal regulations. Some documentation will have to be provided to support specific elements of attestation. All providers will be required to submit supporting documentation for patient volume claimed in the attestation. More information on documentation will be provided in the attestation system.

The first year of the program is the only time a provider is allowed to attest to adopting, implementing or upgrading to certified EHR technology. However, attesting to AIU is not mandatory in the first year. If a provider chooses to attest as a Meaningful User the first year they may do so. All providers will be required to attest to meaningful use to receive incentive payments after attesting to the Adopt, Implement, or Upgrade for the first year.

## **7 INCENTIVE PAYMENTS**

Upon completion of the attestation process, including submission of the electronic attestation, receipt of required documentation and verification by DMS must be completed before an incentive payment can be approved. Providers will be notified of approval for payment by email to the email address submitted with registration. Please be sure the email address provided is current.

## 8 PROGRAM INTEGRITY

DMS has a contract with the Office of Inspector General (OIG) to perform audits and investigations of potential Medicaid fraud and/or abuse; therefore OIG A&I will conduct post payment incentive money audits. The audits conducted will investigate for all things attested; including, but not limited to the certified EHR technology component, percentage of Medicaid population treated, Medicaid eligibility, etc. Any documentation to which an EP or EH attests, including future meaningful use, will be audited. All reviews will ensure that no duplication of payment occurred within the commonwealth system. The OIG A&I will submit reports on audit findings and recommendations to the DMS Division of Program Integrity. All documentation supporting the attestation is to be retained for six years.

### 8.1 Administrative Audits/Appeals

You may appeal the determination made by the Kentucky Department for Medicaid Services on your incentive payment application. In accordance with 907 KAR 6:005 Section 13, to appeal the provider must request a dispute resolution meeting. The request shall be in writing and mailed to and received by the department within 30 calendar days of the date the notice was received. The request must clearly identify each specific issue and dispute, and clearly state the basis on which the department's decision on each issue is believed to be erroneous. The provider shall also state the name, mailing address, and telephone number of individuals who are expected to attend the dispute resolution meeting on the provider's behalf. Any supporting documentation to the appeal should be included with the request. The address to send the request is below:

Division of Program Integrity  
ATTN: EHR Appeal  
Department for Medicaid Services  
275 E. Main Street, 6E-A  
Frankfort, KY 40621

## 9 GETTING STARTED

EPs are required to provide details including patient volume characteristics, EHR details, upload requested documentation and electronically sign the attestation (more details follow in this manual).

EHs and CAHs are required to provide details including patient volume characteristics, EHR details and growth rate. They will complete a Hospital EHR Incentive Payment worksheet as well as upload all requested documentation and electronically sign the attestation (more details follow in this manual).

After registering with the National Level Registry (NLR) at <http://www.cms.gov/EHRIncentivePrograms/>, the provider should receive an email including a

summary of the registration information. The information includes the NPI and registration ID. Please keep this information for login to the Kentucky EHR Incentive Program attestation website (KYSLR) and in case of potential future edits for the NLR.

Please allow 48 hours after registration to log into the KYSLR.

The provider begins the Kentucky Medicaid EHR Incentive Program registration process by accessing the KYSLR system at <https://prdweb.chfs.ky.gov/KYSLR/Login.aspx>.

## 9.1 Sign-in Screen

The provider enters the NPI and CMS assigned Registration Identifier that was returned by the NLR.

If the data submitted by the provider matches the data received from the NLR, the Home Screen will display. If the provider entry does not match, an error message with instructions will be returned.

## 9.2 Home Screen

The Home screen provides announcements, information about the provider's current KY Attestation review as well as provides navigation for the provider to view a previous attestation or begin/modify a new attestation for their next EHR Incentive payment.

KY Medicaid EHR Site
Send E-mail

- Home
- Reports
- View All Payment Years
- Issues/Concerns
- Appeals
- Additional Resources
  - KY Medicaid EHR Site
  - CMS EHR Site
- User Manuals
  - Provider User Manual
  - EP Meaningful Use Manual
  - EHR Meaningful Use Manual

### Home (Year 1 Attestation)

Announcements And Messages

No Announcements and Messages !

Issues/Concerns

Clicking the below link will redirect you to the Issues/Concerns page, where you will be able to submit any issues and view the responses received from the DMS.

[Click Here](#)

Provider Information

You are currently enrolled in KY's EHR Incentive Program.  
 Payment Year '1' is your current year attestation.  
**The current status of your application for the year 1 payment is 'AWAITING PROVIDER ATTESTATION'.**

Stage of Meaningful Use

1st Year	2015	2016	2017	2018	2019	2020
2015	MU Mod Stage 2 w/alt. avail (90 Days)	MU Mod Stage 2 w/alt. avail (365 Days)	MU Mod Stage 2 or Stage 3 (365 Days)	MU Stage 3 (365 Days)	MU Stage 3 (365 Days)	MU Stage 3 (365 Days)

Provider Status Flow

CMS Registration

→

Preliminary Verification

→

Provider Attestation

Completed

In Process

#### Provider Attestation Details

**For which Program Year are you applying?**

**Indicate the status of your EHR:**  Adopt  Implement  Upgrade  Meaningful User

[Save Attestation Details](#)

Attestation details data saved successfully.

#### Provider Attestation Navigation

Payment Year	Status	AttestationID	Action
1	Attest_inProcess	-	<a href="#">Begin/Modify Attestation</a>

There are seven sections to the Home page listed below:

1. **Announcements and Messages** – The first section on the screen displays messages or announcements for the provider.
2. **Issues/Concerns** – The second section on the screen provides a link for the provider to submit a new issue or view a response to an issue.
3. **Provider Information** – The third section of the home screen provides a high-level status for the provider including the current payment year and the current status for the payment year.
4. **Stage of Meaningful Use** – The fourth section of the home screen supplies the stage of Meaningful Use that the provider will need to attest to according to the program year.
5. **Provider Status Flow** – The fifth section of the home screen displays a diagram showing the provider’s current year’s attestation. If the provider has been found not eligible for any reason, specific reasons for that finding shown in this section.
6. **Provider Attestation Details** – The sixth section of the home screen is where the provider selects the Program Year and the status of their EHR in order to attest. The choices for EHR status are:
  - (A) Adopt - Acquire, purchase, or secure access to certified EHR technology.
  - Implement - Install or commence utilization of certified EHR technology capable of meeting meaningful use requirements.
  - (U) Upgrade - Expand the available functionality of certified EHR technology capable of meeting meaningful use requirements at the practice site, including staffing, maintenance, and training, or upgrade from existing EHR technology to certified EHR technology per the ONC EHR certification criteria.
  - (MU) Meaningful User – currently meaningfully using certified EHR technology and are prepared to attest to Meaningful Use and Clinical Quality Measures.
7. **Provider Attestation Navigation** – The seventh section of the home screen lists the provider’s attestations by payment year and provides the navigation actions available for each year. These options may include:
  - View for a previously paid attestation;
  - View Attestation for a completed attestation; or
  - Begin/Modify for a new or not yet completed attestation.

### 9.3 Registration Data Screen

The data provided by the CMS Registration Module is view only. If any of this data is incorrect, then the data must be updated by logging in to the CMS Registration Module, making the updates and re-submission of the registration. Please allow 24 hours for the changes to be reflected.

KY Medicaid EHR Site    Send E-mail

Home

Reports

View All Payment Years

Issues/Concerns

Appeals

Additional Resources

    KY Medicaid EHR Site

    CMS EHR Site

User Manuals

    Provider User Manual

    EP Meaningful Use Manual

    EH Meaningful Use Manual

### Registration Data (Year 1 Attestation)

#### Provider CMS Registration Data

\*\*\* If any of this information is incorrect, please correct on the [CMS Registration Module](#).

<b>Applicant NPI:</b> 033333333	<b>Applicant TIN:</b> 100112233	<b>Name:</b> Danny Zuko	<b>Suffix:</b>
<b>Payee NPI:</b> 033333333	<b>Address :</b> 11 Mill Creek Park , PO Box 11	<b>Payee TIN:</b> 100112233	<b>City/State:</b> Frankfort / KY
<b>Program Option:</b> MEDICAID	<b>Zip Code:</b> 40601 -1234	<b>Medicaid State:</b> KY	<b>Phone Number:</b> 502-564-0105
<b>Provider Type:</b> Certified_Nurse_Midwife	<b>Email:</b> Carla.Cooper@ky.gov	<b>Participation Year:</b> 1	<b>Specialty:</b> Certified_Nurse_Midwife
<b>Federal Exclusions:</b> None	<b>State Rejection Reason:</b> None		

#### Provider Medicaid Attestation Data

\*\*\* Please update the data below in reference to this attestation

Mailing Address:

Address 1:  Medicaid Provider Type:

Address 2:

City:  State:

ZipCode:

Were you assisted by a Regional Extension Center in Kentucky?     Yes  No

[Previous](#)    [Next](#)    [Save](#)    [Cancel](#)

The fields from the CMS registration are listed below:

- **Applicant National Provider Identifier (NPI)** – This is the eligible provider’s individual NPI. The NPI registered at CMS should be the same individual NPI that is enrolled in KY Medicaid.
- **Applicant TIN** – This is the eligible providers Tax Identification Number. This TIN should be the same TIN that is listed for the provider in MMIS.
- **Payee National Provider Identifier (NPI)** – This is the eligible provider’s payee NPI given during the CMS registration. The Payee NPI should be enrolled in KY Medicaid and

listed as a payee with whom the individual provider is a member.

- **Payee TIN** – The tax identification number associated with the payee NPI. This was the tax id given during registration that will have the tax liability of the incentive payment. The Payee TIN should match the FEIN or SSN listed for the payee NPI within KY Medicaid.
- **Program Option** – This program option was selected by the provider during their registration. It will be Medicaid if you are attesting with a State Agency and not Medicare.
- **Medicaid State** – This is the State that was selected during the provider’s registration.
- **Provider Type** – This is the provider type that was given during the registration at CMS. This type will be validated with your type of license.
- **Participation year** – This is the provider’s participation year with the EHR Incentive Program
- **Federal Exclusion** – This will list any federal exclusion found on the provider if any during registration with CMS.
- **Name** – The Provider’s name listed on the CMS Registration
- **Address 1** – The provider’s street address listed on the CMS registration
- **Address 2** – The provider’s street address listed on the CMS registration
- **City/State** – The provider’s city/state listed on the CMS registration
- **Zip Code** – The provider’s zip code listed on the CMS registration
- **Phone Number** – The provider’s phone number given on the CMS registration. This number is used for contact by EHR staff reviewing the attestations.
- **Email** – The provider’s email given during the CMS registration. This email address is used for system-generated emails on updates for the provider’s attestation and communication from the EHR review staff. **Note:** It is very important that this email address be accurate and up-to-date.
- **Specialty** – The provider’s specialty listed in the CMS registration.
- **State Rejection Reason** – This lists the state rejection reason if any are found. This will only list federal codes for rejection, for a more detailed state specific rejection see the home page.

The data listed under the section **Provider Medicaid Attestation Data** is updatable by the provider during attestation. Once the attestation is submitted by the provider, the data will become view only. These data fields are described below:

- **Medicaid ID** - This field only displays if you have multiple Kentucky Medicaid Provider Numbers that are linked to the Payee NPI listed in your CMS registration. If so, you will need to select one of your Kentucky Medicaid Numbers.
- **Medicaid Provider Type** - Please select the provider type from the list. This type should match the type of provider listed under your KY Medicaid enrollment and your type of license.
- **Mailing Address** - The mailing address can be updated if the provider would like to give an alternate address from the one listed from CMS for correspondence.
- **Were you assisted by a Regional Extension Center in Kentucky** - Response to this question is required. If the response is yes, then please type the name of the person

who assisted you during the attestation process.

## 9.4 Provider Eligibility Details Screen

EPs must enter two categories of information to complete the Eligibility Details section including patient volume characteristics and EHR details as well the Service Location section.

EP's:

<p>KY Medicaid EHR Site    Send E-mail</p>	
<ul style="list-style-type: none"> <li>Home</li> <li>Reports</li> <li>View All Payment Years</li> <li>Issues/Concerns</li> <li>Appeals</li> <li>Additional Resources                             <ul style="list-style-type: none"> <li>KY Medicaid EHR Site</li> <li>CMS EHR Site</li> </ul> </li> <li>User Manuals                             <ul style="list-style-type: none"> <li>Provider User Manual</li> <li>EP Meaningful Use Manual</li> <li>EH Meaningful Use Manual</li> </ul> </li> </ul>	<h3>Provider Eligibility Details (Year 1 Attestation)</h3> <div style="border: 1px solid #ccc; padding: 5px; margin-bottom: 10px;"> <p>Eligibility Details:</p> <p>To request a KCHIP report, please complete questions 1-5, click Save Data For KCHIP button, then click Reports link in the navigation menu.</p> <p style="text-align: right; color: red; font-weight: bold;">All * fields are required fields.</p> </div> <p><b>Patient Volume:</b></p> <p>1. Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals: <input type="text" value="No"/></p> <p>2. If yes, please enter the NPI of the clinic or group: <input type="text" value="0"/></p> <p>3. For which program year are you applying? * <input type="text" value="2015"/></p> <p>4. What is the time frame used for patient volume calculation? * <input type="text" value="Prior Calendar Year"/></p> <p>5. Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage: * <input type="text" value="8/18/2014 (mm/dd/yy)"/></p> <p style="text-align: right; margin-right: 50px;"><input type="button" value="Save Data For KCHIP"/></p> <p>6. Medicaid patient encounters during this period (FQHCs/RHCs do NOT include uncompensated care volume in this count. Uncomp care volume needs to be included on the patient volume report.): * <input type="text" value="700"/></p> <p>7. Total patient encounters during this period: * <input type="text" value="1500"/></p> <p>8. Medicaid patient volume percentage: <b>46.67%</b></p> <p><b>EHR Details:</b></p> <p>9. Enter the CMS EHR Certification ID of your EHR: * <input type="text" value="1314E01PQUFUEAN"/> <a href="#">What is this?</a></p> <p>10. Indicate the status of your EHR: * <input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User</p>

EP's continued:

### Service Locations

The practice/location equipped with Certified EHR Technology (CEHRT) can be met in 3 ways:

1. CEHRT is permanently installed at the practice location
2. The CEHRT can be brought to the practice/location on a portable computing device
3. The CEHRT can be accessed remotely using computing devices at the practice/location

\*Do you have multiple service locations?  Yes  No

---

\*Enter the total number of locations:

---

\*Enter the total number of locations with certified EHR Technology:

---

\* Indicate below the service location(s) associated with this attestation that have Certified EHR Technology:

Edit	Address Line 1	Address Line 2	City	State	Zip Code	Zip Code Extension	Delete
<a href="#">Modify</a>	300 What Lane		Frankfort	KY	40601		<a href="#">Delete</a>
<input type="button" value="ADD"/>	<input style="width: 80%;" type="text"/>						

EHRs must enter patient volume characteristics, EHR details, Growth rate information and Medicaid share data.

**EH's:**

<ul style="list-style-type: none"> <li>Home</li> <li>Reports</li> <li>View All Payment Years</li> <li>Issues/Concerns</li> <li>Appeals</li> <li>Additional Resources                             <ul style="list-style-type: none"> <li>KY Medicaid EHR Site</li> <li>CMS EHR Site</li> </ul> </li> <li>User Manuals                             <ul style="list-style-type: none"> <li>Provider User Manual</li> <li>EP Meaningful Use Manual</li> <li>EH Meaningful Use Manual</li> </ul> </li> </ul>	<h3 style="text-align: center;">Hospital Eligibility Details (Year 1 Attestation)</h3> <p style="text-align: right; color: red; font-weight: bold;">(*)Red asterik indicates a required field.</p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20%;"><b>Patient Volume:</b></td> <td style="width: 5%;">1.</td> <td style="width: 60%;">For which program year are you applying?</td> <td style="width: 15%;">* <input type="text" value="2015"/></td> </tr> <tr> <td></td> <td></td> <td><b>What is the time frame used for patient volume calculation?</b></td> <td>* <input type="text" value="Preceding 12"/></td> </tr> <tr> <td></td> <td>2.</td> <td>Select the starting date of the 90-day period(in the prior FFY) to calculate Medicaid patient volume percentage:</td> <td>* <input type="text" value="10/1/2014"/> (mm/dd/yy)</td> </tr> <tr> <td></td> <td>3.(i)</td> <td>Medicaid Inpatient Discharges during this period:</td> <td>* <input type="text" value="1"/></td> </tr> <tr> <td></td> <td>(ii)</td> <td>Medicaid ER/other Discharges (requires attestation):</td> <td>* <input type="text" value="1513"/></td> </tr> <tr> <td></td> <td>(iii)</td> <td>Total Medicaid patient discharges during this period:</td> <td>* <input type="text" value="1514"/></td> </tr> <tr> <td></td> <td>4.</td> <td>Total patient discharges during this period:</td> <td>* <input type="text" value="4960"/></td> </tr> <tr> <td></td> <td>5.</td> <td>Medicaid patient volume percentage:</td> <td><b>30.52%</b></td> </tr> <tr> <td><b>EHR Details:</b></td> <td>6.</td> <td>Enter the CMS EHR Certification ID of your EHR:</td> <td>* <input type="text" value="D14E01EL3XEAV"/> <a href="#">What is this?</a></td> </tr> <tr> <td></td> <td>7.</td> <td>Indicate the status of your EHR:</td> <td>* <input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User</td> </tr> <tr> <td></td> <td></td> <td><b>Please select the cost report you are using?</b></td> <td>* <input type="text" value="Form CMS 2"/></td> </tr> </table>	<b>Patient Volume:</b>	1.	For which program year are you applying?	* <input type="text" value="2015"/>			<b>What is the time frame used for patient volume calculation?</b>	* <input type="text" value="Preceding 12"/>		2.	Select the starting date of the 90-day period(in the prior FFY) to calculate Medicaid patient volume percentage:	* <input type="text" value="10/1/2014"/> (mm/dd/yy)		3.(i)	Medicaid Inpatient Discharges during this period:	* <input type="text" value="1"/>		(ii)	Medicaid ER/other Discharges (requires attestation):	* <input type="text" value="1513"/>		(iii)	Total Medicaid patient discharges during this period:	* <input type="text" value="1514"/>		4.	Total patient discharges during this period:	* <input type="text" value="4960"/>		5.	Medicaid patient volume percentage:	<b>30.52%</b>	<b>EHR Details:</b>	6.	Enter the CMS EHR Certification ID of your EHR:	* <input type="text" value="D14E01EL3XEAV"/> <a href="#">What is this?</a>		7.	Indicate the status of your EHR:	* <input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User			<b>Please select the cost report you are using?</b>	* <input type="text" value="Form CMS 2"/>
<b>Patient Volume:</b>	1.	For which program year are you applying?	* <input type="text" value="2015"/>																																										
		<b>What is the time frame used for patient volume calculation?</b>	* <input type="text" value="Preceding 12"/>																																										
	2.	Select the starting date of the 90-day period(in the prior FFY) to calculate Medicaid patient volume percentage:	* <input type="text" value="10/1/2014"/> (mm/dd/yy)																																										
	3.(i)	Medicaid Inpatient Discharges during this period:	* <input type="text" value="1"/>																																										
	(ii)	Medicaid ER/other Discharges (requires attestation):	* <input type="text" value="1513"/>																																										
	(iii)	Total Medicaid patient discharges during this period:	* <input type="text" value="1514"/>																																										
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	5.	Medicaid patient volume percentage:	<b>30.52%</b>																																										
<b>EHR Details:</b>	6.	Enter the CMS EHR Certification ID of your EHR:	* <input type="text" value="D14E01EL3XEAV"/> <a href="#">What is this?</a>																																										
	7.	Indicate the status of your EHR:	* <input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User																																										
		<b>Please select the cost report you are using?</b>	* <input type="text" value="Form CMS 2"/>																																										

**EH's continued:**

<b>Growth Rate:</b>	<b>8.</b>	Select the end date of the hospital's most recently filed 12-month cost reporting period:	* <input type="text" value="12/1/2011"/> (mm/dd/yy)
	<b>9.</b>	Total number of discharges that fiscal year:	* <input type="text" value="300"/> (w/s S-3, Part I, Col. 15, Line 12)
	<b>10.</b>	Total number of discharges one year prior:	* <input type="text" value="200"/>
	<b>11.</b>	Total number of discharges two years prior:	* <input type="text" value="200"/>
	<b>12.</b>	Total number of discharges three years prior:	* <input type="text" value="200"/>
<b>Medicaid Share:</b>	<b>13.</b>	Total Medicaid inpatient bed days (Exclude Nursery beds):	* <input type="text" value="200"/> (w/s S-3, Part I, Col. 5, Line 1 + Lines 6-10)
	<b>14.</b>	Total Medicaid HMO inpatient bed days (Exclude Nursery beds):	* <input type="text" value="200"/> (w/s S-3, Part I, Col. 5, Line 2)
	<b>15.</b>	Total inpatient bed days:	* <input type="text" value="500"/>
	<b>16.</b>	Total hospital charges:	* <input type="text" value="1000.00"/> (w/s C, Part I, Col. 8, Line 101)
	<b>17. (i)</b>	Inpatient Uncompensated Care Charges :	* <input type="text" value="500.00"/> (KMAP-4, Line 4)
	<b>(ii)</b>	Non-Inpatient Uncompensated Care Charges :	* <input type="text" value="250.00"/> (Upload signed supporting documentation)
	<b>(iii)</b>	Total uncompensated care charges:	* <input type="text" value="750.00"/>

**9.4.1 Eligibility Details**

Eligibility details section allows the user to view or enter information depending on the source of the information and the status of the attestation. Information in this section includes patient volume and information about EHR use.

**Patient Volume  
EPs**

Eligibility Details:	
To request a KCHIP report, please complete questions 1-5, click Save Data For KCHIP button, then click Reports link in the navigation menu.	
All * fields are required fields.	
<b>Patient Volume:</b>	1. Please indicate if your patient volume was calculated at a clinic or practice level for all Eligible professionals: <input type="text" value="No"/>
	2. If yes, please enter the NPI of the clinic or group: <input type="text" value="0"/>
	3. For which program year are you applying? * <input type="text" value="2015"/>
	4. What is the time frame used for patient volume calculation? * <input type="text" value="Prior Calendar Year"/>
	5. Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage: * <input type="text" value="01/01/2014"/> (mm/dd/yy)
<input type="button" value="Save Data For KCHIP"/>	
	6. Medicaid patient encounters during this period (FQHCs/RHCs do NOT include uncompensated care volume in this count. Uncomp care volume needs to be included on the patient volume report.): * <input type="text" value="700"/>
	7. Total patient encounters during this period: * <input type="text" value="1500"/>
	8. Medicaid patient volume percentage: <b>46.67%</b>

1. To enter patient volume, complete the following steps: Please indicate if your patient volume was calculated at a clinic or practice level for all eligible professionals: Yes or No. Please note if you are submitting at the clinic or practice levels **all** EPs from the clinic or practice must also submit their volume at the clinic or practice level for the same program year.
2. If yes, please enter the NPI of the clinic or group.
3. The Program year is displayed from the selection made at the Home screen.
4. Select the time frame used for patient volume calculation. Select from the drop down menu either the "Prior Calendar Year" or "Preceding 12 Months of the date of attestation".
5. Select the starting date of the 90-day period to calculate Medicaid encounter volume percentage. Enter as mm/dd/yy. This date should be a continuous 90-day period.

6. Enter Medicaid patient encounters during this period.
7. Enter Total patient encounters during this period.
8. Medicaid patient volume percentage is calculated based on the volume numbers entered and is displayed as a percentage with two decimals points.  
Volume thresholds are calculated using the EP's total number of *Medicaid* member encounters for the 90-day period as the numerator and *all* patient encounters for the same EP over the same 90-day period as the denominator.

**EHS:**

(\*)Red asterik indicates a required field.

<b>Patient Volume:</b>	1. For which program year are you applying?	*	2015
	<b>What is the time frame used for patient volume calculation?</b>	*	Preceding 12
	2. Select the starting date of the 90-day period(in the prior FFY) to calculate Medicaid patient volume percentage:	*	01/01/2015 (mm/dd/yy)
	3.(i) Medicaid Inpatient Discharges during this period:	*	1
	(ii) Medicaid ER/other Discharges (requires attestation):	*	1513
	(iii) Total Medicaid patient discharges during this period:	*	1514
	4. Total patient discharges during this period:	*	4960
	5. Medicaid patient volume percentage:		30.52%

1. The Program year is displayed from the selection made at the Home screen.
2. Select the time frame used for patient volume calculation.  
Select from the drop down menu either the "Prior Calendar Year" or "Preceding 12 Months of the date of attestation".
3. Starting date of the consecutive 90-day period to calculate Medicaid patient volume percentage.  
This date should be a 90-day period within the Federal Fiscal Year OR preceding 12 months of the date of attestation prior to the program year selected above.
4. (i) Medicaid Inpatient discharges during this period  
(ii) Medicaid ER/other discharges during this period  
(iii) Auto-calculation of (i) and (ii)
5. Total patient discharges during the period
6. Medicaid patient volume percentage is calculated based on the volume numbers entered and is displayed as a percentage with two decimals points.

Volume thresholds are calculated using the EP's total number of *Medicaid* member encounters for the 90-day period as the numerator and *all* patient encounters for the same EP over the same 90-day period as the denominator.

### 9.4.2 EHR Details

EHR Details contain the CEHRT id of the EHR system you are utilizing for attestation as well as the status of the system.

The screenshot shows a form titled "EHR Details". It contains two numbered steps:

- Step 9:** "Enter the CMS EHR Certification ID of your EHR:". To the right is a text input field containing the alphanumeric string "1314E01PQUFUEAN". Below the input field is a blue hyperlink that says "What is this?".
- Step 10:** "Indicate the status of your EHR:". To the right are three radio button options: "Adopt", "Implement", and "Upgrade". The "Adopt" radio button is selected. Below these options is a checkbox labeled "Meaningful User".

9. Enter the CMS EHR certification ID of your EHR. This 15 digit alphanumeric ID issued to your vendor identifies the certified EHR technology to demonstrate meaningful use and can be obtained by entering your certified EHR technology product information on the ONC website <https://chpl.healthit.gov/#/resources>.
10. The status of your EHR is displayed from your selection made on the Home screen.

### 9.4.3 Service Locations

#### EPs ONLY

In the Service location section, enter information about the service locations equipped with a certified EHR. Practice/Locations equipped with CEHRT can qualify for meaningful use in the following ways:

- CEHRT is permanently installed at the practice location.
- The CEHRT can be brought to the practice/location on a portable computing device.
- The CEHRT can be accessed remotely using computing devices at the practice/location.

To complete this section, perform the following steps:

1. Indicate if you have multiple locations.  
Yes or No  
If yes, enter the number of locations with EHR technology.  
If no, the total number of locations with EHR technology will automatically populate with a 1.
2. Enter service location address by clicking on the "Enter Service Location Address" button.

Service Locations

The practice/location equipped with Certified EHR Technology (CEHRT) can be met in 3 ways:

1. CEHRT is permanently installed at the practice location
2. The CEHRT can be brought to the practice/location on a portable computing device
3. The CEHRT can be accessed remotely using computing devices at the practice/location

\*Do you have multiple service locations?  Yes  No

\*Enter the total number of locations:

\*Enter the total number of locations with certified EHR Technology:

[Enter Service Location Address](#)

\* Indicate below the service location(s) associated with this attestation that have Certified EHR Technology:

[Previous](#) [Next](#) [Save](#) [Cancel](#)

3. A new window displays allowing the user to enter a service location address as shown below. Enter an address for all required fields. After entering the address, click on the Add button.

\* Indicate below the service location(s) associated with this attestation that have Certified EHR Technology:

Address 1:

Address 2:

City:

State:

Zip Code:

ZipCode Extension:

[Add](#)

4. Edits or add additional Service location by using the modify and add functions. To remove a service location use the delete function. To add a service location enter the Address, City, State, and Zip code into the fields provided and select the add button.

## 9.5 Incentive Payment Calculation Screen

The incentive payment calculation screen lists the estimated payment for the providers for the current attestation.

EPs:

**Incentive Payment Calculations (Year 1 Attestation)**

Estimated Amount of Medicaid EHR Incentive Payment:	\$21,250.00
(This amount may also include adjustments)	

Previous
Next

**EHS:**

<a href="#">KY Medicaid EHR Site</a> <a href="#">Send E-mail</a>																																																																
<a href="#">Home</a>	<p><b>Incentive Payment Calculations (Year 1 Attestation)</b></p> <div style="border: 1px solid black; padding: 5px;"> <p><b>Patient Volume Calculations</b></p> <table border="1"> <tr> <td>Medicaid Patient Volume Percentage:</td> <td>30.52%</td> <td>* should be greater than 10% to qualify</td> </tr> <tr> <td>Rate of growth prior year:</td> <td>-11.483%</td> <td></td> </tr> <tr> <td>Rate of growth 2 years prior:</td> <td>-0.524%</td> <td></td> </tr> <tr> <td>Rate of growth 3 years prior:</td> <td>-9.048%</td> <td></td> </tr> <tr> <td>Average rate of growth:</td> <td>-7.018%</td> <td>* use this growth rate to project number of discharges for year 2 through year 4 below</td> </tr> </table> </div> <div style="border: 1px solid black; padding: 5px; margin-top: 10px;"> <p><b>EHR Amount Calculations</b></p> <table border="1"> <thead> <tr> <th>Year</th> <th>Discharges</th> <th>Allowable Discharges</th> <th>Discharge Related Amount</th> <th>Base Amount</th> <th>Aggregate EHR amount</th> <th>Transition Factor</th> <th>EHR Amount</th> </tr> </thead> <tbody> <tr> <td>First year</td> <td>1850</td> <td>701</td> <td>\$140,200.00</td> <td>\$2,000,000</td> <td>\$2,140,200.00</td> <td>1.00</td> <td>\$2,140,200.00</td> </tr> <tr> <td>Second Year</td> <td>1720</td> <td>571</td> <td>\$114,200.00</td> <td>\$2,000,000</td> <td>\$2,114,200.00</td> <td>.75</td> <td>\$1,585,650.00</td> </tr> <tr> <td>Third Year</td> <td>1599</td> <td>450</td> <td>\$90,000.00</td> <td>\$2,000,000</td> <td>\$2,090,000.00</td> <td>.50</td> <td>\$1,045,000.00</td> </tr> <tr> <td>Fourth Year</td> <td>1487</td> <td>338</td> <td>\$67,600.00</td> <td>\$2,000,000</td> <td>\$2,067,600.00</td> <td>.25</td> <td>\$516,900.00</td> </tr> <tr> <td><b>Total Amount</b></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td><b>\$5,287,750.00</b></td> </tr> </tbody> </table> </div>	Medicaid Patient Volume Percentage:	30.52%	* should be greater than 10% to qualify	Rate of growth prior year:	-11.483%		Rate of growth 2 years prior:	-0.524%		Rate of growth 3 years prior:	-9.048%		Average rate of growth:	-7.018%	* use this growth rate to project number of discharges for year 2 through year 4 below	Year	Discharges	Allowable Discharges	Discharge Related Amount	Base Amount	Aggregate EHR amount	Transition Factor	EHR Amount	First year	1850	701	\$140,200.00	\$2,000,000	\$2,140,200.00	1.00	\$2,140,200.00	Second Year	1720	571	\$114,200.00	\$2,000,000	\$2,114,200.00	.75	\$1,585,650.00	Third Year	1599	450	\$90,000.00	\$2,000,000	\$2,090,000.00	.50	\$1,045,000.00	Fourth Year	1487	338	\$67,600.00	\$2,000,000	\$2,067,600.00	.25	\$516,900.00	<b>Total Amount</b>							<b>\$5,287,750.00</b>
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<a href="#">EH Meaningful Use Manual</a>																																																																

Medicaid Share Calculations		
Total Medicaid and Passport Inpatient Bed Days:	1358	
Total Bed Days:	7077	
Percentage of total charges which are non-charity: ((total charges - uncompensated charges)/ total charges)	95.82%	
Total Beds that should be considered non charity:	6782	
Total Medicaid Percentage:	20.02359%	
Total Medicaid Aggregate EHR Incentive Payment:	\$1,058,797.48	
Total Estimated Medicaid Aggregate EHR Incentive : Payment for Year 1 (50%)	\$529,398.74	(This amount may also include adjustments)

Previous
Next

## 9.6 Documentation Upload Screen

Documentation is required to support attestation review and verification. This page will allow the provider to attach documentation with their current year attestation. Only PDFs below 100MB can be uploaded. Documentation uploaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre-payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.

- Clicking the browse button will allow the provider to search and select the documents they would like to attach.
- Clicking the upload button will attach and save the document relating to the current attestation payment year.

If you cannot attach a PDF, then use the Send E-mail link on the top left side of the screen to contact the EHR staff for assistance.

### Document Upload (Year 1 Attestation)

Documentation needed to process your application may be attached below. If you cannot attach a PDF then use the Send E-mail link on the left to contact the EHR staff for assistance.

Required Documents for AIU & MU attesters:

1) Proof of certified technology being attested for your practice or facility. This can be: • a signed contract • a signed lease • a current invoice • a license agreement • a purchase order (PO) • or other legal documents showing that you have contracted with a certified EHR vendor for adopt, implement or upgrade.

Additional Required Documents for MU attesters:

- 2) KHIE on-boarding documentation.
- 3) Documentation on your testing with other entities as well as documentation supporting your Public Health Measure response.
- 4) Payment reassignment documentation if payment is assigned to any other NPI than the individual NPI.
- 5) Patient volume report.

If you are using Medicaid patients from multiple states you could be requested to provide additional documentation.

**Please Note: Documentation loaded with the attestation does not alleviate the provider from being requested to produce additional documentation that may be requested during a pre payment or post payment audit. All documentation supporting the information attested by the Provider or Facility should be kept for 6 years.**

Payment Year	File Name	Description
No uploaded document found.		

Upload a new PDF document:

Please select the documentation type:

### 9.7 Attestation Statement Screen

This screen will provide a screenshot of all information submitted during the AIU attestation. Please verify the information on this screen is correct. If it is not, please select the previous option to review or modify any information you may have entered on the previous screens. Once all information on this screen is reviewed and correct please enter your initials and NPI number in the appropriate fields and select the submit button.

EPs:

KY Medicaid EHR Site    Send E-mail

---

Home

Reports

View All Payment Years

Issues/Concerns

Appeals

Additional Resources

- [KY Medicaid EHR Site](#)
- [CMS EHR Site](#)

User Manuals

- [Provider User Manual](#)
- [EP Meaningful Use Manual](#)
- [EHR Meaningful Use Manual](#)

### Attestation (Year 1 Attestation)

**Please verify the following information:**

Provider Registration Data:

<b>Applicant NPI:</b> 0000000001	<b>Applicant TIN:</b> 000000001	<b>Name:</b> Test Test	<b>Suffix:</b>
<b>Payee NPI:</b> 0000000001	<b>Address 1:</b> 123 E Main st , 3 E-W	<b>Payee TIN:</b> 000000001	<b>City/State:</b> Frankfort / KY
<b>Program Option:</b> MEDICAID	<b>Zip Code:</b> 40601 -1234	<b>Medicaid State:</b> KY	<b>Phone Number:</b> 000000001
<b>Provider Type:</b> Physician	<b>Email:</b> Carla.Cooper@ky.gov	<b>Participation Year:</b> 1	<b>Specialty:</b> Physician

Provider Medicaid Attestation Data:

Mailing Address:

Address 1:  
123 millcreek

Address 2:  
3 E-W

City: Frankfort                      State: KY

ZipCode: 40601                      1234

Were you assisted by a Regional Extension Center in Kentucky?     Yes  No

Please give the name of the person who assisted you:                      Carla Mitchell

Eligibility Details:		
<b>Patient Volume:</b>	Was patient volume was calculated at a clinic or practice level for all Eligible professionals:	No <input type="button" value="v"/>
	If yes, Please enter the NPI of the clinic or group:	0
	For which program year are you applying?	2015 <input type="button" value="v"/>
	What is the time frame used for patient volume calculation?	Prior Calendar Year <input type="button" value="v"/>
	I am not hospital based(less than 90% of my patient encounters are at the ER or in an inpatient setting)	'Y'
	The starting date of the 90-day period to calculate Medicaid encounter volume percentage:	6/16/2014 (mm/dd/yy)
	Medicaid patient encounters during this period (FQHCs/RHCs do NOT include uncompensated care volume in this count. Uncomp care volume needs to be included on the patient volume report.):	700
	Total patient encounters during this period:	1500
<b>EHR Details:</b>	Enter the CMS EHR Certification ID of your EHR:	1314E01PQUFUEAN
	Indicate the status of your EHR:	<input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

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

All \* fields are required fields.

Initials: \*

NPI: \*

Note: Once you press the submit button below, you will not be able to change your information.

Previous

Submit



Hospital Eligibility Details:		
<b>Patient Volume:</b>	<b>1.</b>	For which program year are you applying? <input type="text" value="2015"/>
		What is the time frame used for patient volume calculation? <input type="text" value="Preceding 12 Months"/>
	<b>2.</b>	Select the starting date (in 2010) of the 90-day period to calculate Medicaid patient volume percentage: <input type="text" value="10/1/2014 (mm/dd/yy)"/>
<b>EHR Details:</b>	<b>3.</b>	Medicaid Inpatient Discharges during this period: <input type="text" value="1"/>
	<b>(i)</b>	Medicaid ER/other Discharges (requires attestation): <input type="text" value="1513"/>
	<b>(ii)</b>	Total Medicaid patient discharges during this period: <input type="text" value="1514"/>
	<b>(iii)</b>	Total patient discharges during this period: <input type="text" value="4960"/>
	<b>4.</b>	Total patient discharges during this period: <input type="text" value="4960"/>
	<b>5.</b>	Enter the EHR certification number of your EHR: <input type="text" value="3000000SJRO5EAO"/>
	<b>6.</b>	Indicate the status of your EHR: <input checked="" type="radio"/> Adopt <input type="radio"/> Implement <input type="radio"/> Upgrade <input type="radio"/> Meaningful User
<b>Growth Rate:</b>	<b>7.</b>	Select the end date of your last full hospital fiscal year that ended prior to September 30, 2010: <input type="text" value="12/1/2011 (mm/dd/yy)"/>
	<b>8.</b>	Total number of discharges that fiscal year: <input type="text" value="1850 (w/s S-3, Part I, Col. 15, Line 12)"/>
	<b>9.</b>	Total number of discharges one year prior: <input type="text" value="2090"/>
	<b>10.</b>	Total number of discharges two years prior: <input type="text" value="2101"/>
	<b>11.</b>	Total number of discharges three years prior: <input type="text" value="2310"/>

<b>Medicaid Share:</b>	<b>12.</b> Total Medicaid inpatient bed days (Exclude Nursery beds):	194 (w/s S-3, Part I, Col. 5, Line 1 + Lines 6-10)
	<b>13.</b> Total Medicaid HMO inpatient bed days(Exclude Nursery beds):	1164 (w/s S-3, Part I, Col. 5, Line 2)
	<b>14.</b> Total inpatient bed days:	7077 (w/s S-3, Part I, Col. 6, Lines 1,2 + Lines 6-10)
	<b>15.</b> Total hospital charges:	92332250.00 (w/s C, Part I, Col. 8, Line 101)
	<b>16. (i)</b> Total InPatient Uncompensated Care Charges:	2246471.00 (KMAP-4, Line 4)
	<b>(ii)</b> Total Non-InPatient Uncompensated Care Charges	1608575.00 ( Upload signed supporting documentation)
	<b>(iii)</b> Total uncompensated care charges:	3855046.00

I understand that I must have, and retain, documentation to support my eligibility for incentive payments and that the Department for Medicaid Services may ask for this documentation. I further understand that the Department for Medicaid Services will pursue repayment in all instances of improper or duplicate payment. I certify I am not receiving Medicaid EHR incentive funds from any other state or commonwealth and have not received a payment from the Kentucky Department for Medicaid Services for this year.

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

All \* fields are required fields.

Initials: \*

NPI: \*

Note: Once you press the submit button below, you will not be able to change your information.

Previous

Submit

## 9.8 View All Payments Screen

The payments screen allows the user to view previous payments including the payment year, amount, date and type. To access the screen, click on the View All Payment Years link in the navigation menu on the left side of the screen. This screen is a read only screen that displays any payments or adjustments made to the provider by payment year.

The screenshot shows a web application interface. At the top, there are links for 'KY Medicaid EHR Site' and 'Send E-mail'. On the left is a vertical navigation menu with the following items: Home, Reports, Meaningful Use Questionnaire, Meaningful Use Menu Options, Meaningful Use Core Measures, Meaningful Use Menu Measures, Clinical Quality Measures Submission, Pre-Attestation Measure Summary, View All Payment Years, Issues/Concerns, Appeals, Additional Resources, KY Medicaid EHR Site, CMS EHR Site, User Manuals, Provider User Manual, EP Meaningful Use Manual, and EH Meaningful Use Manual. The main content area is titled 'Payments (Year 2 Attestation)' and contains a section labeled 'Payments Details:' followed by a table.

NPI	Payment Year	Payment Amount	Payment Date	Adjustment Amount	Adjustment Date
2111111111	1	21,250.00	1/2/2010	-200.00	7/18/2012
2111111111	1	21,250.00	1/2/2010	500.00	10/5/2012
2111111111	1	21,250.00	1/2/2010	-100.00	10/9/2012

## 9.9 Issues / Concerns Screen

The provider may also view and submit issues or concerns by selecting the Issues/Concerns link in the menu on the left side of the screen. The screen:

- Allows the user to view previous issues and concerns
- Allows user to view current responses to issues and concerns
- Allows user to submit additional issues or concerns

To submit Issue/Concerns, select an issue category from the dropdown list and enter the details of the issue or concern. The issue or concern will be saved and submitted to the EHR staff upon clicking the submit button.

- Home
- Reports
- View All Payment Years
- Issues/Concerns
- Appeals
- Additional Resources
  - KY Medicaid EHR Site
  - CMS EHR Site
- User Manuals
  - Provider User Manual
  - EP Meaningful Use Manual
  - EH Meaningful Use Manual

### Issues/Concerns (Year 2 Attestation)

If you have any issue with the determination of your incentive payment application including but not limited to Eligibility, Patient volume or Payment Amount, you can notify us using the form below. Please be further advised that you also have access to a formal appeal process.

**Issues/Concerns List:**

View Issue	Date Entered	Issue/Concern Status	Issue/Concern Description	Issue Category	
<a href="#">Acknowledge</a>					

**Resolved Issues/Concerns List:**

	Issue/Concern Response	Responded By	Date Responded	Issue/Concern Status	Issue Category
<a href="#">Acknowledge</a>	It works!	carla.mitchell	1/18/2013 4:07:49 PM	Resolved	Other

**Below is the issue and the corresponding response you selected from the Resolved Issues/Concerns List:**

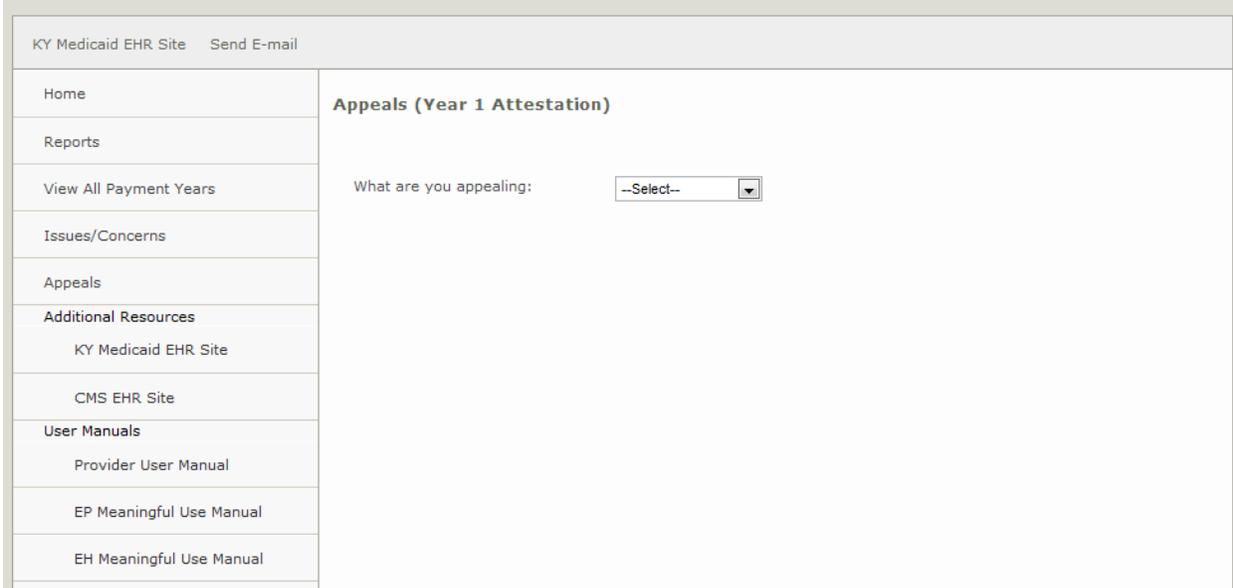
Issue Category:  [Click here to open a new issue.](#)

Description:

Response:

## 10 AUDIT AND APPEALS

This section of the User manual includes information about features that are available to the provider from the Appeals link in the menu on the left side of the screen.

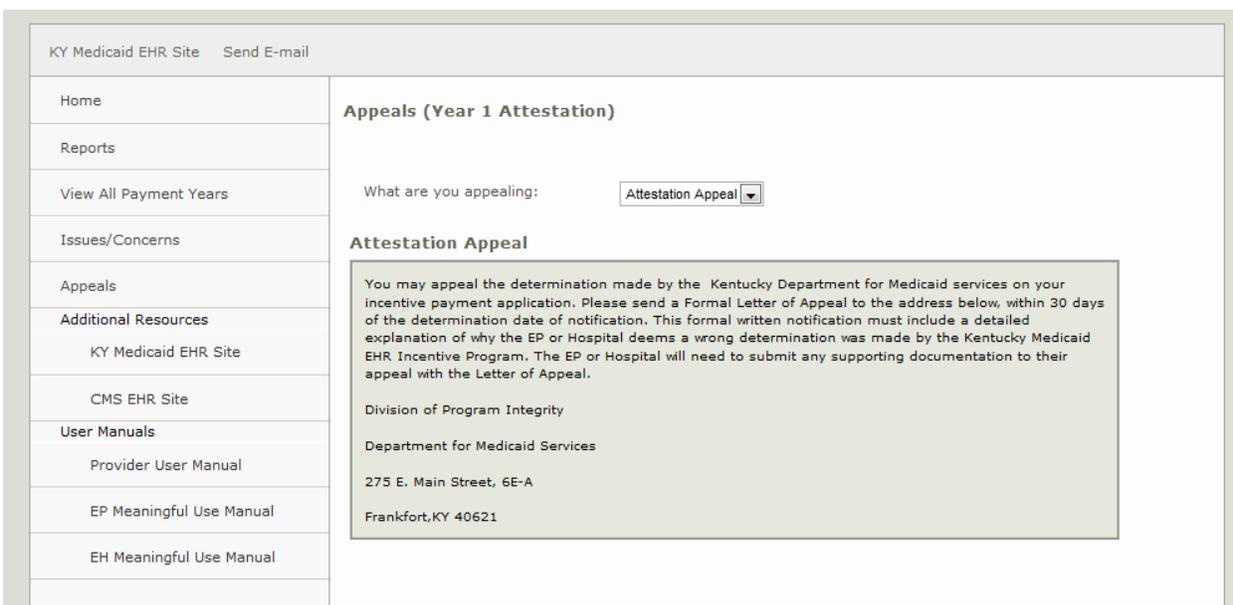


Upon selecting the “Appeals” Link from the menu on the left, the user will be given a dropdown menu to select from.

- Clicking on the Attestation Appeal option will direct the provider to a screen that will detail the process of submitting a formal letter of appeal.
- Clicking on the Audit Appeals Process will direct the provider to a screen that will show an audit grid displaying the status of any audits.

## 10.1 Attestation Appeals Screen

The Appeals screen informs the provider of how to initiate an appeal and provides contact information for the appeal.



## 10.2 Provider Audit Appeal Screen

If there are any audits, the user may view audit information by selecting the audit using the Select link in the row for the audit grid.

KY Medicaid EHR Site
Send E-mail

- [Home](#)
- Reports
- View All Payment Years
- Issues/Concerns
- Appeals
- Additional Resources
- KY Medicaid EHR Site
- CMS EHR Site
- User Manuals
- Provider User Manual
- EP Meaningful Use Manual
- EH Meaningful Use Manual

### Appeals (Year 3 Attestation)

What are you appealing: Audit Appeal

#### Provider Audit Appeal

Name	NPI	Payee NPI	CCN	Status	Start date	Program Year	Select
Test User	0444444444	0444444444		Audit Completed	4/11/2013	2012	<a href="#">Select</a>
Test User	0444444444	0444444444		Audit Completed	4/11/2013	2012	<a href="#">Select</a>
Test User	0444444444	0444444444		Audit Completed	4/11/2013	2012	<a href="#">Select</a>

## 10.3 Audit Appeal Details Screen Appeal Setup Tab

If the provider would like to appeal the audit, the select Audit Appeal option from the dropdown. Select the audit to be appealed using the select button.

After the provider selects the audit, screen is displayed providing a summary of the audit including case number, name, and other identifying information. The screen also displays information about the audit including status, view appeals, review findings, any appeals document that have been uploaded and view the outcome of an appeal.

Home	<p><b>(Year 3 Attestation)</b></p> <p><b>Summary</b></p> <p><b>Audit Case Number:</b> 78                      <b>Audit Status:</b> Audit Completed</p> <p><b>Name:</b> Test User                      <b>NPI:</b> 0444444444</p> <p><b>Payee NPI:</b> 0444444444                      <b>Address:</b> 275 E. Main street, PO Box 1234, Frankfort, KY, 40601</p> <p><b>Audit Program Year:</b> 2012                      <b>Audit Payment Year:</b> 1</p> <p><b>Appeal Status:</b> Appeal dismissed without prejudice</p> <p> <a href="#">Appeal Setup</a>   <a href="#">Findings</a>   <a href="#">Appeal Document Upload</a>   <a href="#">Appeal Outcome</a> </p> <p><b>Appeal Setup</b></p> <p><b>Appeal File Date:</b> <input type="text" value="4/10/2013"/></p> <p><b>Appeal Reason:</b> <input type="text" value="Other"/></p> <p><b>Appeal Type:</b> <input type="text" value="Adopt Implement and Upgrade"/></p> <p><b>Appeal Notes:</b></p> <p>Test</p> <p><input type="text"/></p> <p> <input type="button" value="Previous"/>    <input type="button" value="Next"/> </p>
Reports	
View All Payment Years	
Issues/Concerns	
Appeals	
Additional Resources	
KY Medicaid EHR Site	
CMS EHR Site	
User Manuals	
Provider User Manual	
EP Meaningful Use Manual	
EH Meaningful Use Manual	

To create an appeal, the user will:

- 1) Select the date appeal is to be filed
- 2) Select the type of appeal from the dropdown list.
- 3) Enter any notes related to the appeal as text in the text box. (Maximum of 8,000 characters).

**Appeal Setup**

**Appeal File Date:** 4/10/2013

**Appeal Reason:** Other

**Appeal Type:** Adopt Implement and Upgrade

**Appeal Notes:** Test

Previous Next

After the user completes the appeal set-up, the user may save the appeals using the Next button.

### 10.4 Audit Appeal Details Screen Findings Tab

The findings tab provides information about any finding related to the appeal. If there are finding, information will be displayed in the appeals finding grid including start date, end date, notes, and provider comments if any. If the audits indicated that provider action was required, then the box in the grid will have a check.

The provider may submit comments related to an appeal finding. First select the finding if more than one by clicking on the select button for the desired finding.

**Appeal Findings**

Start Date	End Date	Notes	Provider Comments	Provider Action Required
------------	----------	-------	-------------------	--------------------------

Previous Next

Enter comments in the text box labeled Provider Comments. After completing the comment click save or save and next. If the user clicks save, the comment will be displayed in the Provider comment grid.

### 10.4.1 Audit Appeal Details Screen Appeal Document Upload

This screen is where the provider will upload any documentation related to their audit appeal.

- User will select the “Browse” and then select the document for upload
- From the dropdown menu the user will select the document type
- Upon selection of the Upload button your Appeal information will be submitted and the document information will display in the Document Upload grid.

Note: Documents for upload are limited to PDF format and files size not to exceed 100 MB.

### 10.4.2 Audit Appeal Details Screen Appeal Outcome Tab

This tab will show the outcome of your appeal and include information or comments relating to your audit.