



## Calendar Year 2015 ELIGIBLE PROFESSIONAL 2015 HARDSHIP EXCEPTION APPLICATION

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### MEDICARE 2015 Electronic Health Record (EHR) INCENTIVE PROGRAM INFORMATION

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#### Returning Eligible Professionals (EPs) to the EHR Incentive Program

- If you successfully met Meaningful Use in 2013, you will be **excluded** from the payment adjustment and do not need to submit a Hardship Exception Application for Payment Year 2015.
- If you did not successfully meet Meaningful Use in 2013 and you would like to apply for a Hardship Exception, you must submit your Application no later than midnight EDT on July 1, 2014.

#### Eligible Professionals that have **not** participated in the EHR incentive Program

- If you have not previously participated in the EHR Incentive Program and would like to participate for Program Year 2014, you have until October 1, 2014 to successfully attest and avoid the 1% payment reduction for Medicare Part B claims.
- If you have not previously participated in the EHR incentive program and would like to submit a Hardship Exception Application, you must submit your Application no later than midnight EDT on July 1, 2014.

#### Eligible Professionals that **DO NOT** need to complete this form

- **Specialties** - If you are classified in the Medicare Provider Enrollment, Chain and Ownership System (PECOS) as having one of the following 5 specialty codes as your primary area of practice you **DO NOT** need to submit this form. You will be granted a Hardship Exception and are automatically exempt from the 2015 payment adjustment based on the data in PECOS.
  - Diagnostic Radiology (30)
  - Nuclear Medicine (36)
  - Interventional Radiology (94)
  - Anesthesiology(05)
  - Pathology (22)

**New EPs** - If you are a new EP enrolling in the Medicare program, you **DO NOT** need to submit this form. You will be granted a Hardship Exception and are automatically exempt from the 2015 payment adjustment based on the data in PECOS. For additional information, please refer to the EP Tip Sheet at the following address [http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj\\_HardshipExcepTipSheetforEP.pdf](http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_HardshipExcepTipSheetforEP.pdf)

**Hospital-Based EPs** - If you are a hospital-based EP for 2012 or 2013, you **DO NOT** need to submit this form. You will be granted a Hardship Exception and are automatically exempt from the 2015 payment adjustment based on the data in PECOS.



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## BASIC APPLICATION INFORMATION

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- This Application must be fully completed for any EP to formally file a Hardship Exception Application within the Medicare EHR Incentive Program. To file a Hardship Exception Application, the circumstance must be beyond the EP's control *and* the EP must explicitly outline how the circumstance significantly impaired the EP's ability to meet Meaningful Use.
- To avoid the 2015 payment adjustment, this Application must be submitted electronically or postmarked by Midnight EDT, on the appropriate deadline of: **July 1, 2014 for all EPs.**
- The date this Application and supporting documentation are received will be the submission date.
- If approved, this Hardship Exception is valid for 1 payment year only. If the EP claims a Hardship Exception for the following payment year, a new Application must be submitted.
- Determinations made by CMS or their designee regarding Hardship Exceptions are final and cannot be appealed.
- All Hardship Exception determinations will be returned to the email address provided.

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## INSTRUCTIONS FOR COMPLETING AND SUBMITTING THIS APPLICATION

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- If you are submitting an application on behalf of multiple EPs, please use the "EP Hardship Multiple NPI Addendum" document in conjunction with this application.
- This Application will be reviewed when the completed form is received along with all required supporting documentation.
- All documentation is required at the time of submission and additional documentation will not be accepted.
- Electronic submission of this Application is strongly recommended. If electronic submission is not possible, please TYPE or PRINT all information using blue or black ink; do not use pencil. Hand-writing this application may result in processing delays.
- This completed Application and all supporting documentation must be attached to an email and sent to [ehrhardship@provider-resources.com](mailto:ehrhardship@provider-resources.com)
- For EPs without Internet connectivity, submit this Application and all supporting documentation via fax to **814-464-0147**.
- Retain a copy of your completed Hardship Exception Application for your records



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## SECTION 1: HARDSHIP APPLICATION INFORMATION

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### Section 1.1 – Check one box and complete the following required sections.

The following types of professionals are defined in 42 CFR §495.100 as eligible to participate in the Medicare EHR Incentive Program. Select the type that best describes your EHR Incentive Program enrollment:

Eligible Professionals (only one option required):

- |  |   |
|--|---|
| <input type="checkbox"/> Doctor of medicine or osteopathy            | <input type="checkbox"/> Chiropractor       |
| <input type="checkbox"/> Doctor of optometry                         | <input type="checkbox"/> Doctor of podiatry |
| <input type="checkbox"/> Doctor of dental surgery or dental medicine |   |



**Section 1.2 – Review the information below and indicate the Hardship Exception you would like to file (check the one reason that best applies to the circumstance preventing demonstration of Meaningful Use).**

REASON FOR APPLICATION	HARDSHIP EXCEPTION INFORMATION	REQUIRED SECTIONS
<input type="checkbox"/> Lack of Infrastructure	<p>During any 90 day period from January 1, 2013 to July 1, 2014 (the beginning of the year that is 2 years before the payment adjustment year to July 1 of the year preceding the payment adjustment year), the EP was located in an area without sufficient Internet access to comply with the Meaningful Use objectives requiring Internet connectivity, and faced insurmountable barriers to obtaining such Internet connectivity.</p>	Complete 2, 3.1 and 4
<input type="checkbox"/> Unforeseen and/or Uncontrollable Circumstances	<p>During the 1 or 2 calendar years (2013 and 2014) preceding the payment adjustment year (2015), the EP faced extreme and uncontrollable circumstances that prevented the EP from becoming a meaningful EHR user.</p>	Complete 2, 3.2 and 4
<input type="checkbox"/> Lack of control over the availability of Certified EHR Technology	<p>An EP may request an exception through an Application submitted by July 1, 2014, due to difficulty in meeting Meaningful Use during the period that begins 2 calendar years before the payment adjustment year through the Application deadline (January 1, 2013 - July 1, 2014):</p> <p>The EP must demonstrate that he/she practices at multiple locations and is unable to control the availability of Certified EHR Technology at one such practice location or a combination of practice locations, and where the location or locations constitute more than 50 percent of patient encounters.</p>	Complete 2, 3.3 and 4
<input type="checkbox"/> Lack of Face-to-Face Interaction	<p>An EP may request an exception through an Application submitted by July 1, 2014, due to difficulty in meeting Meaningful Use during the period that begins 2 calendar years before the payment adjustment year through the Application deadline (January 1, 2013 - July 1, 2014):</p>	Complete 2, 3.4 and 4
<input type="checkbox"/> 2014 EHR Vendor Issues	<p>During the calendar year (2014) preceding the payment adjustment year (2015), the EP's EHR vendor was unable to obtain 2014 certification or the EP was unable to implement Meaningful Use due to 2014 EHR certification delays</p>	Complete 2, 3.5 and 4



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**SECTION 2: PROVIDER INFORMATION**

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**Section 2.1 – Provide the following information regarding the provider that is applying for the Hardship Exception for the EHR Incentive Program (fields marked with \* are required).**

First Name*	Middle Initial	Last Name*	Suffix
Practice Address Line 1 (Street Name and Number – not a Post Office Box)*			
Practice Address Line 2 (Suite, Room, etc.)			
City/Town*		State*	
County*	Zip Code*	+4 (if applicable)	
Email Address (required unless Internet access unavailable)*			
Business Telephone Number (include Area Code)*		Extension	
National Provider Identifier (NPI) (10 digits)*			
EHR Technology Product Name(s) and Version Number used by Provider/Practice			
CMS EHR Certification ID provided by the Office of the National Coordinator (ONC) via <a href="http://onc-chpl.force.com/ehrcert">http://onc-chpl.force.com/ehrcert</a> . If product no longer has a Certification ID, please provide prior Certification ID.			



**Section 2.2 – Optional**

Provide the following information regarding the practice, only if multiple NPIs are applying for the same Hardship Exception type for the EHR Incentive Program (fields marked with \* are required). Also, complete the form for "Submitting Multiple NPIs in a Single Application."

Practice Name*	
Payee NPI (10 digits)*	Total Number of Individual NPIs filing under this Hardship Exception Application*

**Section 2.3 – If applicable, provide the information below for the person working on behalf of the provider applying for the Hardship Exception for the EHR Incentive Program. If no contact person is listed below, all return correspondence will be sent to contact listed in Section 2.1 (fields marked with \* are required).**

First Name*	Middle Initial	Last Name*	Suffix
Mailing Address Line 1*			
Mailing Address Line 2			
City/Town*		State*	
County*	Zip Code	+4 (if applicable)	
Email Address (required unless Internet access is unavailable)*			
Business Telephone Number (include Area Code)*			Extension



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### SECTION 3: HARDSHIP EXCEPTION APPLICATION INFORMATION

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**Section 3: Based on the Application type selected in Section 1.2, complete the appropriate information below**

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**Section 3.1 - Lack of Infrastructure - complete all information in Section 3.1 below.**

What is the size of the practice? (Check one of the following) (\*required)

- |  |   |
|--|---|
| <input type="checkbox"/> Single Physician Practice       | <input type="checkbox"/> Rural Health Clinic (up to 5 physicians) |
| <input type="checkbox"/> Small Practice (2-4 physicians) | <input type="checkbox"/> Clinic/Large Practice (5-25 physicians)  |

Is Internet connectivity available at the practice location by any means? (Check yes or no)

- Yes  
 No

If Internet connectivity is available, what is the minimum bandwidth available at the practice location? (Check one of the following)

- |  |   |
|--|---|
| <input type="checkbox"/> Less than 4 megabits per second (Mbps)      | <input type="checkbox"/> Greater than 100 megabits per second (Mbps)  |
| <input type="checkbox"/> Between 4 and 10 megabits per second (Mbps) | <input type="checkbox"/> Greater than 1000 megabits per second (Mbps) |
| <input type="checkbox"/> Greater than 10 megabits per second (Mbps)  |   |

If Internet connectivity is available, what is the cost associated with establishing the minimum required infrastructure for the EP practice size? (Check one of the following)

- Internet Connectivity not available  
 Internet Connectivity is available at a cost
- |   |                      |
|---|----------------------|
| <input type="checkbox"/> Monthly service fee: \$                    | <input type="text"/> |
| <input type="checkbox"/> One-time infrastructure build-out cost: \$ | <input type="text"/> |

The EP was unable to meet Meaningful Use due to (indicate all that apply):

- The EP cannot transmit data electronically  
 The EP cannot provide patients with electronic access to their health information.  
 The EP cannot submit electronic data to immunization registries or public health agencies  
 Other:

**Items to include with the Application (\*required)**

- Proof of practice size\*  
 Monthly service fee quote from Internet Service Provider (if Internet access available)  
 One-time Infrastructure build-out cost quote from Internet Service Provider (if Internet access available)



**Section 3.2 - Unforeseen and/or Uncontrollable Circumstances**

Review and **indicate one** of the following circumstances outlined below (Sections 3.2.1 through 3.2.4).

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**Section 3.2.1 Disaster - complete all information in Section 3.2.1 below.**

Has the EP previously demonstrated Meaningful Use?

- Yes  
 No

Date of Disaster (MM/DD/YYYY):

Indicate the type of disaster below (at least one option required):

- |  |   |
|--|---|
| <input type="checkbox"/> Fire                              | <input type="checkbox"/> Disaster declared by FEMA or HHS |
| <input type="checkbox"/> Tornado                           | <input type="checkbox"/> Flood                            |
| <input type="checkbox"/> Hurricane/Tropical Storm          | <input type="checkbox"/> Explosion                        |
| <input type="checkbox"/> Other (provide brief description) | <input type="text"/>                                      |

The EP was unable to meet Meaningful Use due to: (Indicate all that apply, but at least one)

- The EP continued seeing patients at a temporary location without access to Certified EHR Technology or lost access to Certified EHR Technology at the primary location
- The EP was unable to recover data necessary to attest to Meaningful Use
- Normal operations were suspended during the Meaningful Use attestation window (anytime from the end of the EHR reporting period to the two months after the year)
- Other:

**Items to include with the Application (\*required unless declared disaster by FEMA or HHS)**

- Proof of disaster (examples: insurance verification, newspaper article with source, etc.)\*
- 

**Section 3.2.2 Closure of Practice - complete all information in Section 3.2.2 below.**

Has the EP previously demonstrated Meaningful Use?

- Yes  
 No

Date of Closure (MM/DD/YYYY):





The EP was unable to meet Meaningful Use due to (indicate all that apply):

- New practice does not use Certified EHR Technology
- Unable to obtain data necessary to attest to Meaningful Use from closed practice
- Other:

**Items to include with the Application (\*required)**

- Proof of closure/dissolution of practice\*
- 

**Section 3.2.3 Bankruptcy or Debt Restructuring - complete all information in Section 3.2.3 below.**

Has the EP previously demonstrated Meaningful Use?

- Yes
- No

Date of Bankruptcy/Debt Restructuring Filing (MM/DD/YYYY):

Is the EP still associated with the organization that filed for bankruptcy/debt restructuring?

- Yes
- No

Date of the expected emergence from the bankruptcy/debt restructuring (MM/DD/YYYY):

**Items to include with the Application (one selection below required)**

- Voluntary Petition - submit a signed and dated Voluntary Petition/Official Form 1 (B1) that was filed with the bankruptcy court (do not include exhibits A, B, C or D or any attached schedules).
  - Involuntary Petition - submit a signed and dated Involuntary Petition/Official Form 5 (B5) that was filed with the bankruptcy court.
  - In the alternative, a copy of the bankruptcy judge's order or judgment issued will be accepted. The document submitted must contain the debtor's name; the docket number; and the date of the court order.
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**Section 3.2.4 EHR Certification/Vendor Issues (indicate one) - complete all information in Section 3.2.4 below.**

- Loss of EHR Certification
- Closure of EHR Vendor

Has the EP previously demonstrated Meaningful Use?

- Yes
- No

Date of Notification from EHR Vendor (MM/DD/YYYY):



Name of EHR product and version number or vendor that has lost certification or closed:

**Items to include with the Application (\*required)**

Notification from EHR vendor\*

**Section 3.3 Lack of control over the availability of Certified EHR Technology - complete all information in Section 3.3 below. This section must be completed by each EP applying for this exception.**

The EP is unable to control the availability of Certified EHR Technology which constitutes more than 50 percent of outpatient encounters. (Check one of the following) (\*required)

At one such practice location **or**  At a combination of practice locations

List the Business Name of each practice location:

At the location(s) indicated above, check all boxes below that apply:

*Note: The EP must be able to answer yes to each statement below or provide justification to be considered for this hardship exception.*

- 1  I have no managerial or executive role
- 2  I have no partnership or ownership stake
- 3  I do not participate in decisions regarding the medical record keeping
- 4  I do not reassign payments for my services to the ownership or management

If 1, 2, or 3 are not selected above, provide an explanation as to why, despite the relationship you have with the location(s), you do not have influence or control over the availability of CEHRT at the location or locations indicated above.

If 4 is not selected above, explain how the payment adjustment would adversely impact you and not the ownership and/or management that does control the availability of CEHRT at the location or locations indicated above

I, (print name of Eligible Professional) \_\_\_\_\_, am requesting this Medicare Payment Incentive Hardship Exception and attest that I am unable to control the availability of Certified EHR Technology (CEHRT) at a location or locations constituting more than 50 percent of my outpatient encounters.

By attesting to this inability to control the availability of CEHRT at one or more of my practice locations, I understand that I may be eligible for a Medicare Payment Incentive Hardship Exception if this difficulty in meeting meaningful use conforms to the criteria under Regulatory Citation: 42 CFR 495.102 (d)(4)(iv).



**Section 3.4 Lack of Face-to-Face Interaction - complete all information in Section 3.3 below. This section must be completed by each EP applying for this exception.**

Please note that if you are classified in PECOS as having one of the following 5 specialty codes as your primary area of practice you DO NOT need to submit this form. You will be granted a hardship exception and are automatically exempt from the 2015 payment adjustment based on the data in PECOS.

- Diagnostic Radiology (30)
- Nuclear Medicine (36)
- Interventional Radiology (94)
- Anesthesiology (05)
- Pathology (22)

The EP has: (Check one of the following) (\*required)

- Complete lack of face-to-face patient interaction and follow-up **or**
- Extremely rare cases of face-to-face patient interaction and follow-up

I, (print name of Eligible Professional) , am requesting this Medicare Payment Incentive Hardship Exception and attest to and can demonstrate (the practice indicated on the Application) a complete lack of face-to-face patient interaction and follow-up or that the cases of face-to-face interaction and follow-up are extremely rare and not a part of my normal scope of practice.

By attesting to a complete lack of face-to-face patient interaction and follow-up or to extremely rare cases of face-to-face patient interaction and follow-up that are not a part of my normal scope of practice, I understand that I may be eligible for a Medicare Payment Incentive Hardship Exception if this difficulty in meeting meaningful use conforms to the criteria under Regulatory Citation: 42 CFR 495.102 (d)(4)(iv).

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**Section 3.5 - 2014 EHR Vendor Issues - complete all information in Section 3.5 below.**

- Vendor unable to obtain 2014 certification
- Provider unable to implement meaningful use due to 2014 EHR certification delays

Has the EP previously demonstrated Meaningful Use?

- Yes
- No



Name of EHR product and version number or vendor:

**Items to include with the Application (\*required)**

Notification from EHR vendor\*



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## SECTION 4: CERTIFICATION STATEMENT FOR HARDSHIP EXCEPTION APPLICATION

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**Section 4: Read the certification statement below and confirm the following:**

### **GENERAL NOTICE**

NOTICE: Any person who knowingly files a statement of claim containing any misrepresentation or any false, incomplete or misleading information may be guilty of a criminal act punishable under law and may be subject to civil penalties.

### **SIGNATURE OF ELIGIBLE PROFESSIONAL**

I certify that the foregoing information is true, accurate, and complete. I understand that the Medicare EHR Incentive Program hardship exception I requested will request in a change in the amount I will be paid from Federal Funds, and that by filling this hardship exception I am submitting a claim for Federal Funds, and the use of any false claims, statements, or documents, or the concealment of a material fact used to obtain a Medicare EHR Incentive Program hardship exception, may be prosecuted under applicable Federal or State criminal laws and may also be subject to civil penalties.

SUBMITTER WORKING ON BEHALF OF A PROVIDER: I certify that I am submitting this application for a hardship exception on behalf of a provider who has given me authority to act as his/her agent. I understand that both the provider and I can be held personally responsible for all information entered.

I hereby agree to keep such records as are necessary to support the application submitted for a hardship exception of the Medicare EHR Incentive Program and to furnish those records both in the application and at a future time upon request from the Department of Health and Human Services, or a contractor acting on their behalf.

No Medicare EHR Incentive Program exception may be granted unless this application is completed and approved as required by existing law and regulations (42 CFR §495.102).

NOTICE: Anyone who misrepresents or falsifies essential information to receive payment from Federal funds requested by this form may upon conviction be subject to fine and imprisonment under applicable Federal laws.

ROUTINE USE(S): Information from this Medicare EHR Incentive Program hardship exception form and subsequently submitted information and documents may be given to the Internal Revenue Service, private collection agencies, and consumer reporting agencies in connection with recoupment of any overpayment made and to Congressional Offices in responses to inquiries made at the request of the person to whom a record pertains. Appropriate disclosures may be made to other federal, state, local and foreign government agencies, private business entities and individual providers of care, on matters relating to entitlement, fraud, program abuse, program integrity, and civil and criminal litigation relation to the operation of the Medicare EHR Incentive Program.



**DISCLOSURES:** This program is an incentives program. Therefore, while submission of information for this program is voluntary, failure to provide necessary information will result in delay in processing the hardship exception application or may result in a denial of a hardship exception for the Medicare EHR Incentive Program payment. Failure to furnish subsequently requested information or documents to support this attestation may result in overpayments and the issuance of an overpayment demand letter followed by recoupment procedures.

It is mandatory that you tell us if you believe you have been overpaid under the Medicare EHR Incentive Program. The Patient Protection and Affordable Care Act, Section 6402, Section 1128J, provides penalties for withholding this information.

By confirming this certification statement, I agree, and it is my intent, to sign this Application and affirmation by including my name and the date below. I understand that completing the information below is the legal equivalent of having placed my handwritten signature on the submitted Application and this affirmation.

**Confirm**

\*Date (MM/DD/YYYY):

\*Type name of individual completing form:

If you are printing out this form, please provide your handwritten signature below.

Signature: