Meaningful Use Audit, Is Your Organization Ready!

Presenters:

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Summary

Attendees will take away from this presentation:

- How to survive a Meaningful Use audit
- How to be Meaningful Use audit compliant
- How to prepare a Book of Evidence
- Gain insight into audit preparedness
- What’s On The Horizon?
How to survive a Meaningful Use Audit

Who is conducting the audits and at what percentage?

Since 2012, CMS, through its contractor, Figliozzi and Company, has audited the meaningful use attestations of EPs and EHs that participate in the Medicare EHR Incentive Program.

_EHR Intelligence reported_ in October that more than 650 audits of eligible hospitals and 10,000 audits of eligible professionals have taken place since the CMS program began. Only 4.9 percent of hospitals have failed the audits, but more than 20 percent of professionals have had to return meaningful use payments as a result of failing audits.
How to survive a Meaningful Use Audit

Pre-Payment audit and Post-Payment Audit - No Longer "pay and chase"

An audit can be a pre-payment or a post-payment audit and may be a desk audit or a field (on-site) audit.

During a field audit, auditors may require a demonstration of the Certified EHR.
How to survive a Meaningful Use Audit

Pre-Payment Audit:

January 1, 2013 - CMS started conducting EHR Incentive Program pre-payment audits

Pre-payment audits check supporting documentation to validate attestation data before CMS releases their incentive payment.
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Post-Payment Audit:

Post-payment audits require supporting documentation to validate submitted attestation data.

A failed audit could result in CMS recoupment of its incentive payments, and the discovery of knowingly false claims could lead to additional civil penalties and criminal prosecution.
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How long should I retain the data?

An audit can occur anytime in the six-year period following attestation. CMS recommended maintaining these records for at least six years following attestation.

Maintain all attestation documentation in a well organized, centralized location that is secure and backed up. If not electronic, then a second copy to an offsite bunker.

Due to the statute of limitations under the federal False Claims Act, it is recommended that all records be maintained for at least 10 years.
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How will you be contacted for your audit?

You will receive an email notification from ...@figliozzi.com and signed by Peter Figliozzi CPA, CFF, FCPA.

Make sure this email address domain is white listed in your email system so it will not be identified as spam.

Also, email address being sent to will be the CMS Registration and Attestation website email address so make sure that email address is active and up-to-date.
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Sample of the Audit Request Letter
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What to do if I'm contacted?

Immediately contact your vendors for assistance during the audit.
How to be Meaningful Use audit compliant

Obtain EHR Certification Identification Number

CMS EHR Certification Identification Number is a number generated by the Certified Health IT Product List (CHPL) used for reporting to CMS for Meaningful Use attestation. It represents a product or combination of products in the CHPL.

**Warning!!!** Do not use the vendor product certification number

Each Hospital must obtain their own unique CMS EHR Certification ID from the Certified Health IT Product List website cart.

[Compliance Certificate](#)
How to be Meaningful Use audit compliant

Steps to obtaining CMS EHR Certification ID

Add product(s) to the cart to determine if your product(s) meet 100% of the required criteria. [http://oncchpl.force.com/ehrcert](http://oncchpl.force.com/ehrcert)

The CMS auditing firm uses the same CMS website to verify you have met 100% of the required criteria.
100% Criteria Met
90% Criteria Met

<table>
<thead>
<tr>
<th>Base Criteria</th>
<th>CQM Domains</th>
<th>Inpatient CQMs</th>
<th>Ambulatory CQMs</th>
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<tbody>
<tr>
<td>(90%)</td>
<td>(100%)</td>
<td>(100%)</td>
<td>(0%)</td>
</tr>
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</table>

2 PRODUCT(S) IN CART

<table>
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<tr>
<th>Certifying Body</th>
<th>Original Practice Type</th>
<th>Vendor</th>
<th>Product</th>
<th>Product Version #</th>
<th>Product Classification</th>
<th>Additional Software Required</th>
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<td>Drummond Group Inc.</td>
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<td>Medical Information Technology, Inc.</td>
<td>MEDITECH Client/Server Electronic Health Record Core HCIS (without Electronic Prescribing 170.314(b)(3))</td>
<td>5.66</td>
<td>Modular EHR</td>
<td>Remove</td>
</tr>
</tbody>
</table>
How to be Meaningful Use audit compliant

Request a CMS EHR Certification ID for CMS registration or attestation from your cart page

Once you request the CMS EHR Certification ID save the file in book of evidence for supporting documentation
How to be Meaningful Use audit compliant

Stop all compilation jobs

Disable all compilation jobs once Medical Records has completed coding and abstracting for the reporting period and the hospital is ready to attest.
How to be Meaningful Use audit compliant

Lock your Attestation data!

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
<th>Numerator</th>
<th>Denominator</th>
<th>Performance Met</th>
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<tr>
<td>CM-1a</td>
<td>Use computerized provider order entry (CPOE) for medication orders</td>
<td>59355</td>
<td>85334</td>
<td>✅</td>
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<tr>
<td>CM-1b</td>
<td>Use computerized provider order entry (CPOE) for radiology orders</td>
<td>74966</td>
<td>96226</td>
<td>✅</td>
</tr>
<tr>
<td>CM-1c</td>
<td>Use computerized provider order entry (CPOE) for laboratory orders</td>
<td>11624</td>
<td>13742</td>
<td>✅</td>
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<tr>
<td>CM-2</td>
<td>Record demographics</td>
<td>7923</td>
<td>7977</td>
<td>✅</td>
</tr>
<tr>
<td>CM-3</td>
<td>Record and chart changes in vital signs</td>
<td>7847</td>
<td>7977</td>
<td>✅</td>
</tr>
<tr>
<td>CM-4</td>
<td>Record smoking status for patients 13 years old or older</td>
<td>6187</td>
<td>6352</td>
<td>✅</td>
</tr>
<tr>
<td>CM-6a</td>
<td>EHR available online within 36 hours of discharge</td>
<td>5026</td>
<td>8011</td>
<td>✅</td>
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<tr>
<td>CM-6b</td>
<td>Provide patients the ability to view online, download, and transmit information about a hospital admission</td>
<td>5026</td>
<td>8011</td>
<td>✅</td>
</tr>
<tr>
<td>CM-8</td>
<td>Incorporate clinical lab test results as structured data</td>
<td>155241</td>
<td>161604</td>
<td>✅</td>
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</tbody>
</table>
How to prepare a Book of Evidence

- General Information
- Payment Eligibility
- Certified EHR Technology (CEHRT)
- Capabilities Enabled and Tested
- Standards Requirements
- Privacy & Security Requirements
- Threshold Reporting Requirements
How to prepare a Book of Evidence

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Do you have proof that all required certified software was in place and in use during the entire reporting period?

Owning it and using are two different issues to the auditor.

CMS FAQ  https://questions.cms.gov/faq.php?id=5005&faqId=2893
How to prepare a Book of Evidence

Do you have documentation on the reporting method your hospital selected?

CMS auditors want to see a document explaining why you selected one of the reporting methods; Observation Method or ALL ED Method.

Should be applied consistently throughout the reporting period.

Sample letter

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Is your hospital using fully certified software for attestation?

Make sure you have a copy of the certification documentation when you secure your CMS ID number and also in your attestation book of evidence supporting documentation.

You can check your vendors' certifications by going to the Certified Health IT Product List (CHPL) website.

http://oncchpl.force.com/ehrcert?q=CHPL
Are your selected CQM’s certified?

Hospital EHR vendors can be certified as complete EHR’s if they comply with all base measures, but don’t have the ability to create all 29 Clinical Quality Measures.
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Was the certified software installed for the full reporting period date range?

Provide documentation including software name and version number with proof showing you were using all certified solutions. The version numbers are critical for audit compliance.

CMS FAQ: https://questions.cms.gov/faq.php?id=5005&faqId=2893
How to prepare a Book of Evidence

Reporting measures that are Yes/No based also need supporting documentation.

You must have proof that demonstrates that this functionality was active throughout the entire reporting period.

Sample drug-drug / drug-allergy audit report
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Are you including vendor name and version number on the summary and detail reports?

The auditors request that any supporting documentation include vendor name and version number from the vendor of record to prove that the reports were created from a Meaningful Use certified system.

Sample core measure summary report
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Have you completed a security risk analysis?

The Office of the National Coordinator for Health Information Technology has published the “Guide to Privacy and Security of Health Information” as a reference.

Page 26 Step 10: Attest for the Security Risk Analysis MU Objective:

Providers can register for the EHR Incentive Programs anytime, but they can only attest after they have met the meaningful use requirements for an EHR reporting period. Only attest for an EHR incentive program, after you have fulfilled the security risk analysis requirement and have documented your efforts.

Do not attest for an EHR Incentive program until you have conducted your security risk analysis (or reassessment) and corrected any deficiencies identified during the risk analysis. Document these changes.
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Have you generated a patient list report?

Generating at least one report listing patients of the eligible hospital or CAH with a specific condition.

Sample core measure patient list
How to prepare a Book of Evidence

Do you have audit logs from your HIE/HISP?

Transitions of Care measure 2 requires 10% of referrals by eligible providers/hospitals to be sent electronically.

Requirements:
- Must be different billing identities
- The summary of care record must be received by the provider...

CMS FAQ: https://questions.cms.gov/faq.php?faqId=9690
### Core Measures Summary

**From: 10/1/2013 Thru: 9/30/2014**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Measure Description</th>
<th>Denominator</th>
<th>Numerator</th>
<th>Performance Not Met</th>
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<td>CM-1a</td>
<td>Use computerized provider order entry (CPOE) for medication orders</td>
<td>85334</td>
<td>59555</td>
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<td>69.8 %</td>
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<td>CM-1b</td>
<td>Use computerized provider order entry (CPOE) for radiology orders</td>
<td>96226</td>
<td>74966</td>
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<td>CM-1c</td>
<td>Use computerized provider order entry (CPOE) for laboratory orders</td>
<td>13742</td>
<td>11624</td>
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<td>30.0 %</td>
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<td>CM-2</td>
<td>Record demographics</td>
<td>7977</td>
<td>7923</td>
<td>54</td>
<td>99.3 %</td>
<td>80.0 %</td>
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<td>CM-3</td>
<td>Record and chart changes in vital signs</td>
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<td>7847</td>
<td>130</td>
<td>98.4 %</td>
<td>80.0 %</td>
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<tr>
<td>CM-4</td>
<td>Record smoking status for patients 13 years old or older</td>
<td>6352</td>
<td>6187</td>
<td>165</td>
<td>97.4 %</td>
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<tr>
<td>CM-6a</td>
<td>EHR available online within 36 hours of discharge</td>
<td>8011</td>
<td>5026</td>
<td>2985</td>
<td>62.7 %</td>
<td>50.0 %</td>
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<td>CM-6b</td>
<td>Provide patients the ability to view online, download, and transmit information about a hospital admission</td>
<td>8011</td>
<td>5026</td>
<td>2985</td>
<td>62.7 %</td>
<td>5.0 %</td>
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<td>CM-8</td>
<td>Incorporate clinical lab test results as structured data</td>
<td>161604</td>
<td>155241</td>
<td>6363</td>
<td>96.1 %</td>
<td>55.0 %</td>
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<td>CM-10</td>
<td>Patient specific educational resources provided</td>
<td>7979</td>
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<td>Perform medication reconciliation</td>
<td>9735</td>
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<td>CM-12b</td>
<td>Summary of care record for each transition of care</td>
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<td>2434</td>
<td>7202</td>
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<td>CM-16</td>
<td>Track medications from order to administration using electronic medication administration record</td>
<td>62797</td>
<td>58488</td>
<td>4309</td>
<td>93.1 %</td>
<td>10.0 %</td>
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### Visit Details

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<td>X0-820131105111516670</td>
<td>7/8/14 0:09</td>
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<tr>
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<table>
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</tbody>
</table>
How to prepare a Book of Evidence

Watch out for this hidden Yes/No Measure!

Summary of Care - CM-12c: Measure 3: Electronic Exchange of Summary of Care Record

Certified EHR with a Direct address

CMS EHR Randomizer to generate a test Direct address
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What if audit criteria is not met?

You will receive a Follow-Up Request

Core Measure #2 Drug Interaction Checks: The screenshots provided demonstrate the drug interaction check functionality in the EHR system. However, is there any additional documentation that you could supply to prove that this functionality was enabled for the entire EHR reporting period?

Proof of Access: We are unable to verify the formulary product version number utilized during the attestation period. An example of sufficient documentation would be a letter from the vendor stating the product version number the EP utilized during the attestation period.
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Final Follow-up Request

You will receive a Final Follow-up Request

Based on our review of the submitted documentation to date, we have determined that you have not supplied sufficient documentation for the following....

Please submit the requested information by 5/20/2014. After this date, we will be making the final audit determination. Please be aware that if the aforementioned meaningful use criteria are not met, the incentive payment will be recouped.
How to be Meaningful Use audit compliant

Hardship Exception Timelines

The submission period for hardship exception applications to avoid the 2017 Medicare payment adjustments.

The new deadline will be July 1, 2016

CMS: Hardship Exception Application
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General Information

- Audit documentation pertains to the actual reporting period attested
- Documentation to support emergency department (ED) volume calculation method
  - Observation services or All ED
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Payment Eligibility

- Reports used to identify the number of total discharges
- CMS cost reports for the reporting year
- Reports used to establish Medicaid inpatient days and discharges for computing Medicaid eligibility
- Patient volume data from prior years
How to prepare a Book of Evidence

- Certified EHR Technology (CEHRT)
  - Contracts for all CEHRT modules, including details such as the name of the vendor, product & version
  - “Additional software required” retain documentation
  - Certified Health IT Product List (CHPL) documentation
  - Summary of care method of transmission (HISP, HIE)
What’s On The Horizon?

- 2017 IPPS Validation Requirements
- Medicare Access & CHIP Reauthorization Act of 2015
- Advancing Care Information Audit Requirements
- Enhanced Oversight and Accountability
### 2017 IPPS Validation Requirements

<table>
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<th>Current Validation Process</th>
<th>Number of Hospitals</th>
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<td>400</td>
</tr>
<tr>
<td>Chart-Abstracted Targeted</td>
<td>200</td>
</tr>
<tr>
<td>Total</td>
<td>600</td>
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</table>

<table>
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<th>Number of Hospitals</th>
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<td>400</td>
</tr>
<tr>
<td>Chart-Abstracted Targeted</td>
<td>200</td>
</tr>
<tr>
<td>eCQM: random</td>
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</tr>
<tr>
<td>Total</td>
<td>800</td>
</tr>
</tbody>
</table>
Enhanced Oversight and Accountability

- ONC expands role of oversight
- Attest to cooperation with certain authorized IT surveillance and oversight activities
- Clinicians required to give access to their EHR
- No restriction of data sharing and interoperability
Questions

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Pavan Attur, pattur@primehealthcare.com