H. Preparing for a Meaningful Use Audit

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This presentation and the related materials provide general guidance on Meaningful Use audits. They do not constitute legal advice.

If you need legal advice, please consult your lawyer.
Types of audits

- Medicare and Medicaid
- Pre-payment and post-payment
- Medicare pre-payment audits began with attestations submitted during and after January 2013
- So far, most audits are desk audits and not on-site audits, but on-site audits are possible

Who will be audited?

- Any provider who receives an EHR incentive payment under either the Medicare or Medicaid EHR Incentive Program is subject to audit
- Some audits are random and some providers are specifically selected for an audit
Data that may lead to an audit

- CMS has noted that “suspicious or anomalous” data may lead to an audit
- Examples:
  - Same denominators in all percentage based measures
  - Small denominators in percentage based measures
  - 100% on all percentage based measures
  - Multiple attempts to identify 90-day period to establish patient volume (Medicaid)

When do audits occur?

- Audits can occur anytime in the six year period following attestation
- Keep documentation for at least six years
- Documentation supporting payment calculations should follow current retention requirements
What documentation should be maintained?

• Auditors may request and review any documentation supporting the attestation
• Medicaid audit requests may vary by state

Proof of use of Certified EHR

• Need to provide certification number of EHR, which can be obtained from the Certified Health IT Product List
• License agreement, purchase order, etc. may be requested but determine whether sharing is permitted
• Some Certified EHR vendors provide license summary to provide to auditors
• Some Certified EHR vendors also prohibit sharing screen shots unless approved
• Consider potential issues with EHR upgrades
Source document

• Maintain the “source document”
• This is the primary document relied on when completing the attestation
• This is normally a report from the Certified EHR system

Source document (cont.)

• The source document should include the following:
  – Numerators and denominators for the measures
  – Time period the report covers
  – Evidence to support that it was generated for that provider
• Clinical quality measures must be reported from the Certified EHR, so maintain a report to validate the clinical quality measures reported
Security risk analysis

• Meaningful use requires a provider to conduct or review a security risk analysis as required by the HIPAA security rule
• The security risk analysis must include the Certified EHR
• Guidance from CMS and OCR confirms that a security risk analysis must be conducted during each Stage 1 and Stage 2 reporting period

Documentation for Yes/No measures

• Screen shots from the Certified EHR from the reporting period
  – Screen shots should show date, provider, and Certified EHR
  – If screen shots aren’t possible, can the information be obtained another way?
  – Determine whether there are any contractual restrictions on providing screen shots
**Documentation for transmissions**

- Maintain documentation regarding electronic exchange of information. For example:
  - Screen shots demonstrating test exchange
  - Letter or email from provider or entity on the other end of the exchange
- Note recent changes to measures regarding electronic transmissions

**Documentation for exclusions**

- Example: Health Department doesn’t accept electronic submissions. Can usually obtain a statement from the Health Department or its website
- Example: Immunizations not part of an EP’s practice. Document this and save with other attestation paperwork
Medicaid-specific issues

- Documentation of volume calculations
- States may have different requirements for proof of adoption, implementation, or upgrade
  - Some states may require only an agreement or purchase order for Certified EHR
  - Other states may require proof of actual implementation

Other issues

- Documenting that at least 50% of patient encounters were recorded in the Certified EHR
- Reporting on all patients seen, not just patients whose records are maintained in the Certified EHR
- EPs working in multiple locations
CMS Guidance

- Refer to checklist provided for more information on preparing for an audit

Meaningful Use Audits

Questions and Discussion