



Audits, Audits, and More Audits

CMS EHR Incentive Program Attestation Audits

White paper compliments of EMR Advocate, Inc.

Authors: Jim Tate, Roberta Mullin, and Joy Rios

For more information on MU Audits visit: www.MeaningfulUseAudits.com

Contents

Introduction	2
History of the CMS EHR Incentive Programs	3
Timeline.....	3
Current Federal Rules	4
Medicare Audits.....	5
Medicare Appeals	8
Medicaid Audits and Appeals	10
Best Practices for Audit Preparation and Response	11
Frequent Areas of Concern	12
Security Risk Analysis	12
Patient List	12
Exclusions.....	12
Public Health	13
OIG Work Plans 2014 and 2015	14
OIG MU Audits	14
Mock Audit.....	15
Mock Audit Services.....	16
Disclaimer.....	17

Introduction



CMS lays it out there as concisely as possible: “Any provider attesting to receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Program potentially can be subject to an audit”. Pre-payment, post-payment, Medicare, Medicaid, dually-eligible, Eligible Professionals (EP), Eligible Hospitals (EH), national level, state level and yes, even Office of the Inspector General (OIG) oversight audits. How can you tell the players without a scorecard? Audits related to the CMS EHR Incentive programs have continued to change over time both in the nature and source of the audits. Some of the processes have matured into paths that are predictable while others continue to reflect confusion

and inconsistently.

At EMR Advocate, Inc. our involvement with audits based on the MU program began in June 2011. Since that time our experience with a large number of EP and EH audits and appeals we have become aware of certain themes that have arisen and areas of potential risk have been identified. This white paper is a snapshot in time based on current direct knowledge.

About the Authors

Jim Tate - Jim is a nationally recognized expert on the CMS EHR incentives and the “meaningful use of certified technology”. He has worked with over 200 EHR vendors on their ONC certification projects, authored the first manual on MU, and served as a Subject Matter Expert to the federally funded Regional Extension Centers for the adoption and implementation of electronic health records.

Roberta Mullin – Roberta has 30 years of software development, system implementation and training, and technical support, the past fifteen of which spent in the medical and health IT fields. As a Medicare provider she has experience with compliance and billing. She has been analyzing and writing about the CMS EHR Incentive programs since its inception.

Joy Rios - Joy is a subject matter expert in Meaningful Use, EHRs, and PQRS. She helps healthcare professionals navigate government incentive programs by developing EHR training programs, authoring Meaningful Use and PQRS coursework, and writing regularly about Health IT. She holds an MBA and is a Certified Healthcare Technology Specialist, with a focus in Workflow Redesign. Her guidebook for PQRS is available at www.greenbranch.com/pqrs.

History of the CMS EHR Incentive Programs

The HITECH Act of 2009 was created to stimulate the adoption of electronic health care technology by a combination of financial incentives and fee adjustments. Since that time over \$30 billion has been received by providers who have attested to the “meaningful use of certified technology.” To make sure those incentives are justified, a vigorous audit program has been initiated that could occur up to six years after incentive attestation. A failed audit results in recoupment of 100% of received incentives for that specific “meaningful use” year.

Timeline

First payment year	Stage of meaningful use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021
2011	1	1	1	*1 or 2	2	2	3	3	TBD	TBD	TBD
2012		1	1	*1 or 2	2	2	3	3	TBD	TBD	TBD
2013			1	*1	2	2	3	3	TBD	TBD	TBD
2014				*1	1	2	2	3	3	TBD	TBD
2015					1	1	2	2	3	3	TBD
2016						1	1	2	2	3	3
2017							1	1	2	2	3

First year as a meaningful EHR user	Stage of meaningful use										
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021 and future years
2011	1	1	1	*2	2	2	2 or 3	3	3	3	3
2012		1	1	*2	2	2	2 or 3	3	3	3	3
2013			1	1	2	2	2 or 3	3	3	3	3
2014				1	1	2	2 or 3	3	3	3	3
2015					1	1	1, 2 or 3	3	3	3	3
2016						1	1, 2 or 3	3	3	3	3
2017							1, 2 or 3	3	3	3	3
2018 and future years								3	3	3	3

Current Federal Rules



Find more information about the CMS EHR Incentive Programs on the CMS website.

- [Eligibility](#)
- [Registration](#)
- [Attestation](#)
- [Audits and Appeals](#)



Find more information about EHR standards, certified technologies, and policy on HealthIT.gov.

- [EHR Adoption](#)
- [Certification Program](#)

Stage 1 - Data Capture and Sharing

- 7/28/2010, issued by CMS - Medicare and Medicaid Programs; Electronic Health Record Incentive Program – [Regulations.gov](#).
- 7/28/2010, issued by ONC - Health IT: Initial Set of Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology – [Regulations.gov](#).
- 12/29/2010, issued by CMS - Medicare and Medicaid Programs: EHR Incentive Program; Correcting Amendment – [Regulations.gov](#).
- 1/7/2011, issued by ONC - Establishment of Permanent Certification Program for Health Information Technology – [Regulations.gov](#).
- 11/28/2011, issued by ONC - Permanent Certification Program for Health IT: Revisions to ONC-Approved Accreditor Processes – [Regulations.gov](#).

State 2 - Advance Clinical Processes

- 9/4/2012, issued by CMS - Medicare and Medicaid Programs: EHR Incentive Program-Stage 2 – [Regulations.gov](#).
- 9/4/2012, issued by ONC - Health IT: Standards, Implementation Specifications, and Certification Criteria for Electronic Health Record Technology, 2014 Edition, etc. – [Regulations.gov](#).
- 10/23/2012, issued by CMS - Medicare and Medicaid Programs: EHR Incentive Program - Stage 2; Corrections – [Regulations.gov](#).
- 9/4/2014, issued by CMS and ONC - Medicare and Medicaid Programs: Modifications to the Medicare and Medicaid EHR Incentive Program for 2014 and Other Changes – [Regulations.gov](#).
- 9/11/2014, issued by ONC - 2014 Edition Release 2 EHR Certification Criteria and the ONC HIT Certification Program: Regulatory Flexibilities, Improvements, and Enhanced Health Information Exchange – [Regulations.gov](#).
- 4/15/2015, NPRM from CMS - Medicare & Medicaid Programs; EHR Incentive Program Modifications to MU in 2015-2017 – [Regulations.gov](#).

Stage 3 – Improved Outcomes (Proposed Rules)

- 3/30/2015, NPRM from CMS - Medicare and Medicaid Programs: Electronic Health Record Incentive Program Stage 3 – [Regulations.gov](#).
- 3/30/2015, NPRM from ONC - Health IT Certification Criteria, Base EHR Definition, and ONC Health IT Certification Program Modifications – [Regulations.gov](#).

Medicare Audits

CMS has awarded a contract to a single firm to perform MU audits for Medicare or dually-eligible (Medicare and Medicaid) program participants. That firm, Figliozi and Company, conducts both pre-payment and post-payments MU audits directed against a single specific MU attestation. This private firm has contracted with CMS “to conduct meaningful use audits of certified Electronic Health Record (EHR) technology” and has “the right to audit and inspect any books and records of any organization receiving an incentive payment.” The auditing firm’s compensation is not based on audit outcomes or the potential recoupment of received incentive payments. In our experience with numerous EPs and EHs undergoing audit we have found the Figliozi auditors to be transparent in their expectation of acceptable documentation. To put it simply, there is no financial advantage to the auditor if you fail the audit.

The use of an individual entity with centralized auditing protocols for all Medicare incentive audits provides the foundation for a consistent process whether the provider is a solo practitioner in Utah or a large hospital system in Florida. Audits can take place after attestation either pre- or post-payment. Audits that are conducted pre-payment have consequences on expected incentive payments. Audits that are conducted post payment, which can occur up to 6 years after attestation, have consequences on received incentive payments.

Notification of a MU audit engagement comes by email to the contact individual identified as the representative of the provider at [the CMS EHR Incentive Program Registration website](#). The communication from the auditor states, “This letter is to inform you that your organization has been selected by the CMS for an audit of your facility’s meaningful use of certified EHR technology for the attestation period. Attached to this letter is an information request list. Be aware that this list may not be all-inclusive and that we may request additional information necessary to complete the audit.” Following is a sample letter.

Notification of a MU audit engagement comes by email to the contact individual identified as the representative of the provider at [the CMS EHR Incentive Program Registration website](#).



February 25, 2013

Dr. John Smith
MD, FAAFP
123 East Blvd
Dallas, Texas 75206

**RE: HITECH EHR Meaningful Use
Audit Engagement Letter & Information Request**

Dear Dr. Smith,

The Centers for Medicare and Medicaid Services (CMS) has contracted with Figliozi & Company, CPAs P.C.¹ to conduct meaningful use audits of certified Electronic Health Record (EHR) technology as required in Section 13411 of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as included in Title XIII, Division A, Health Information Technology and in Title IV of Division B, Medicare and Medicaid Health Information Technology of the American Recovery and Reinvestment Act of 2009. The HITECH Act provides the Secretary, or any person or organization designated by the Secretary, the right to audit and inspect any books and records of any person or organization receiving an incentive payment.

This letter is to inform you that you have been selected by CMS for an audit of your meaningful use of certified EHR technology for the attestation period. Attached to this letter is an information request list. Be aware that this list may not be all-inclusive and that we may request additional information necessary to complete the audit.

¹ Please feel free to contact the EHR Information Center at 1-888-734-6433 or log onto the CMS EHR Website at <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Attestation.html#10>.



Please supply all requested items by March 11, 2013, by utilizing one of the following methods:

1. Electronically uploading the information to our secure web portal (*see step by step instructions attached*)
2. Mailing the information to:

Figliozi & Company, CPAs P.C.
585 Stewart Avenue
Suite 416
Garden City, NY 11530

The contracts between CMS and its contractors contain a confidentiality of information clause that state propriety information or data submitted by or pertaining to an organization cannot be released without the prior written consent of the organization. Additionally, the contractors are required to obtain written permission from CMS's contract officer whenever the contractor is uncertain on the proper handling of material under the contract. Further, if any information contained within the records your organization submits to CMS's contractors constitutes confidential information, as such terms are interpreted under the Freedom of Information Act (FOIA) (5 U.S.C. § 552) and applicable case law, CMS will protect such information from release when requested under FOIA in accordance with the Department of Health and Human Services regulations (45 C.F.R. § 5.65 (c)).

If you have any questions, please contact me by email at pfigliozi@figliozi.com or by telephone at (516) 745-6400 extension 302.

Sincerely,

A handwritten signature in black ink, appearing to read 'Peter Figliozi', with a long horizontal flourish extending to the right.

Peter Figliozi CPA, CFF, FCPA

Medicare Appeals



If you are an EH or EP and receive a negative Final Determination at the conclusion of a MU EHR incentive audit you are suddenly behind the eight ball. A failed pre-payment audit is bad enough but a post-payment failure is the absolute pits. The Federal Government is telling you that they want that incentive back, 100% of it for the year your MU attestation was audited. CMS tells us that there may be light at the end of the tunnel through the established appeals process.

If you have been denied an EHR incentive payment, have been determined to be ineligible for the program, or have received an audit decision that you believe to be in error, you can appeal the decision. Medicare eligible professionals (EPs) should file appeals with CMS, while Medicaid eligible professionals should contact their State Medicaid Agency for information about filing an appeal. Medicare eligible hospitals and critical access hospitals (CAHs) should also file appeals with CMS, whereas Medicaid eligible hospitals or any hospital that wants to appeal its Medicaid eligibility should contact their State Medicaid Agency for information about filing an appeal. Because CMS will conduct audits for both Medicare and Medicaid eligible hospitals, all appeals of eligible hospital audits should be filed with CMS.

If you receive notification that you have failed, you will receive instructions of your rights to appeal within 30 days. You will be entering a world that can only be described as a “black box”.

The Medicare MU audit process is well documented. Guidance, clarification, and advice are available from CMS, vendors, bloggers, and all the rest of the usual suspects. During an audit you are in direct communication with an actual human who lets you know their expectations in terms of documentation. There is opportunity to ask for and receive clarification. You are aware of deadlines and when more information is required.

This level of transparency is not the case during an appeal of a failed Medicare MU audit. If you receive notification that you have failed, you will receive instructions of your rights to appeal within 30 days. You will be entering a world that can only be described as a “black box”.

The Medicare MU Incentive Appeal Request Forms for both EPs and EHs inform us:

All documentation is required at the time of submission and additional documentation will not be accepted.... Electronic submission of this request is strongly recommended. This completed request and all supporting documentation must be attached to an email and sent to ehrappeals@provider-resources.com.

In the numerous appeals we have authored, a confirmation email comes back immediately upon submission. Then the silence begins. In the very early days of the MU appeals process a conference call would be arranged by the a member of the appeals staff in which there would be given an opportunity to provide clarifying explanation in support of the appeal. That is no longer an option. In the numerous MU appeals we have authored and submitted on the behalf of EHs and EPs in the past few years there is no such opportunity for dialogue.

During the appeal of a failed Medicare MU audits there is one opportunity to submit additional information. There will be no opportunity for further submissions or explanations. The documentation is prepared and submitted and then you wait. Usually within 60 days a decision rendered. That's it. If your appeal is denied, you will be told that further appeals are allowed. Litigation in Federal Court is always an option, but who wants to do that? Life is too short. To gain a sense of some of the past issues with the appeals process (lost appeals, inconsistent rulings, two sets of rules) you might want to [read a blog post on the topic.](#)

Having to go the appeal route is a bad sign. It means you have not met expectations and without some additional clarification or documentation a reversal is unlikely. If you have failed the audit you want to bring a different approach to the appeal.

Topic Resources

CMS Eligible Professional (EP) Appeal Filing Request: Basic Information Request. [View](#)

CMS Eligible Hospital Appeal Filing Request: Basic Information Request. [View](#)

Medicaid Audits and Appeals

Audits

Unlike the Medicare or dually-eligible (Medicare and Medicaid) providers, there is no central entity responsible for Medicaid audits. Auditing oversight is left up to each state and there is a wide variation in the depth, process, and auditor knowledge from state to state. Since the requirement to meet the desirable designation as a Medicaid provider is based on a percentage threshold of Medicaid care, you can bet this will be an area of focus.



CMS has provided guidance and clarification to the states on how to perform MU audits but the actual process has continued to show wide variance. We expect this to continue. A case in point is the first year requirement for the CMS Medicaid EHR Incentive

program for EPs. The first year does not require the achievement of MU (as opposed to Medicare EPs) but rather the adoption, implementation, or upgrading (A/I/U) of Certified Electronic Health Records Technology (CEHRT). Some states only require proof of registration or licensing with an EHR to meet this measure. Other states require that the EP can demonstrate they have actual access to the EHR. This type of inconsistency in interpretation of the Federal regulations can make the difference between passing or failing an audit.

Appeals

A failed Medicaid MU incentive audit always carries the opportunity for appeal. The appeals are handled on a state by state basis with a process that is specific to the rules and regulations of each state. A notification of a failed Medicaid audit will provide instructions on appeal rights and deadlines. We have seen instances in some states of the opportunity of an “informal appeal” that could take place prior to a formal appeal, since the state based entities that handle the appeal process

Topic Resources

CMS Medicaid State Information. [View](#)

State EHR Incentive Program Milestones and Web Resources guide. [View](#)

Best Practices for Audit Preparation and Response



Preparing for a pre or post-payment audit of a CMS EHR incentive should be considered as part of the entire meaningful use process. Attestations can be withdrawn but not during an audit. Once an audit engagement letter is received from the auditor, the process moves forward to a Final Determination.

- Check validity of contact information for the hospital that was entered with CMS during the initial CMS EHR Incentive Program registration.
- Assign and document who will lead the response team during an audit.
- Identify personnel who will make up the response team.
- Maintain all attestation related material in a secure location for a minimum of 6 years past attestation. Both electronic and paper records are desired.
- During an audit have one point of contact to communicate with the auditor.
- Ask the auditor if you need any clarification on their expectations.
- Adhere to all deadlines.
- Request additional time to supply information if necessary before any deadline.
- Enlist your EHR vendor as a source for resources and documentation.
- Only provide what is specifically requested.
- Seek outside consulting expertise sooner rather than later.

Topic Resources

CMS Stage 1 Audit Guidance – [View](#).

CMS Stage 2 Audit Guidance – [View](#).

CMS Frequently Asked Question Data Base on EHR Incentive Audits – [View](#).

Frequent Areas of Concern

In our work with EPs and EHs we see the same misconceptions on a regular basis. Often there is confusion about exclusions or perhaps the optimum strategy for selection of Menu Measures. Below are the most common issues we encounter.

Security Risk Analysis



Beyond doubt the most misunderstood MU requirement for EPs is the Security Risk Analysis. CMS tell us, “EPs must conduct or review a security risk analysis of certified EHR technology and implement updates as necessary at least once prior to the end of the EHR reporting period and attest to that conduct or review. The testing could occur prior to the beginning of the first EHR reporting period.

However, a new review would have to occur for each subsequent reporting period.” The language is the same for EPs and EHs.

From what we have seen in many CMS MU audits a frequent cause of failure is the absence of a Security Risk Analysis. If you don’t have one that was performed within the proper time window you will fail the audit and all received incentives for that year’s attestation will go back. You can bet on that. Take a look here for the [Top 10 Myth of Security Risk Analysis](#)

Patient List



This should be the easiest of all the MU measures to meet based on the simplicity of “Generate at least one report listing patients of the EP with a specific condition.” The critical detail often overlooked is that the list must be generated **during the reporting period**. CMS suggests the following documentation: “Report with a specific condition that is from the certified EHR system and is dated during the EHR reporting period selected for attestation. Patient-identifiable information may be masked/blurred before submission.”

Exclusions



Documentation to support an exclusion to each measure claimed by the provider. Report from the certified EHR system that shows a zero denominator for the measure or otherwise documents that the provider qualifies for the exclusion.

Public Health

Acceptable documentation to prove these measures can vary widely due to the fact that it may be coming from the EHR or a public health registry or similar organizations. Here is the CMS suggested documentation:



- Dated screenshots from the EHR system that document successful submission to the registry or public health agency. Should include evidence to support that it was generated for that provider's system (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc.).
- A dated record of successful electronic transmission (e.g., screenshot from another system, etc.). Should include evidence to support that it was generated for that provider (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc.).
- Letter or email from registry or public health agency confirming receipt of submitted data, including the date of the submission and name of sending and receiving parties.
- For exclusions to public health reporting objectives, a letter, email, or screenshot from the registry that demonstrates EP was unable to submit and would therefore qualify under one of the provided exclusions to the objective.

OIG Work Plans 2014 and 2015



The mission of the Office of the Inspector General (OIG) is, “to protect the integrity of Department of Health & Human Services (HHS) programs as well as the health and welfare of program beneficiaries.” In OIG’s 2014 and 2015 Work Plans a focus on oversight of the CMS MU EHR Incentive program is clearly stated, “We will perform audits of various covered entities receiving EHR incentive payments from CMS and their business associates, such as EHR cloud service providers, to determine whether they adequately protect electronic health information created or maintained by certified EHR technology.” Simply put, the OIG has a mandate to make sure the CMS EHR Incentive Programs follow established rules and regulations. To that end the OIG has begun MU audits.

OIG MU Audits

The current OIG MU audit process covers multiple attestations. That’s right, you are being asked to produce documentation for numerous reporting periods. There is no mention of recoupment of funds. It appears the OIG process is part of a due diligence effort to generate accurate information for oversight reports. If the OIG audit uncovers problems, will that information be passed on to the other auditing bodies for further review and potential recoupment of incentives? At this time it is not known. The text that states “We are required to report as a security breach” is also a bit on the scary side. Having an MU audit response as being identified as a security breach would be like falling out of the pan into the fire. This is unlike the other MU audits we have encountered.



Some of the questions asked during an OIG MU audit go beyond those in the traditional (Figliozi and State) MU audits. Here are a few of those types of questions asked by one of our hospital clients during an OIG MU audit:

- Who at the facility was involved in choosing the EHR product? What considerations did you take into account when choosing the EHR program you are currently using?
- Who was involved in the registration and attestation process (of the Incentive Payment Program)?
- Does each user of the EHR system have their own unique electronic signature to sign off on documents and is the electronic signature time and date stamped?
- Describe the hospital’s contingency plan if the EHR product goes offline? Please include in your description any use of backup files.

Mock Audit



The purpose of a CMS EHR Incentive mock audit is to prepare for a potential audit by CMS EHR Incentive audit contractors. System response, relevant staff knowledge, and access to pertinent primary and secondary documentation should be tested, reviewed, and documented.

If issues are identified they are documented along with possible mitigation strategies. The mock audit is performed against an individual MU attestation with an identified reporting period.

The mock audit should review numerous aspects of the provider’s ability to respond to an actual audit including:

- Completeness and quality of available documentation (Book of Evidence)
- Appropriate understanding of meaningful use regulations
- Responsiveness to information requests
- Appropriate strategic selection of potential exclusions and menu set objectives
- Presence of acceptable Security Risk Analysis covering the reporting period of the attestation

The stakes have gotten higher and more than ever you want to make sure your “Book of Evidence” is intact and validated.

Mock Audit Services

If you are interested in learning more about the process for conducting a mock audit for your organization, please contact us at: Inquiry@MeaningfulUseAudits.com.

To date, EMR Advocate, Inc. has supported well over 100 Eligible Hospitals, Critical Access Hospitals (CAHs) and Eligible Professionals with meaningful use audits, appeals, and mock audits.

Scope of Work for Conducting a Mock Audit

- Remote mock audit of Client's CMS EHR incentive attestation(s) based on requirements, tools, and processes employed by current CMS EHR incentive audit contractor.
- Full review of all percentage and non-percentage based Meaningful Use (MU) documentation and underlying data.
- Detailed review of Security Risk Assessment
- Clarification and guidance to Client on proper documentation of MU attestation process, document production, and safe-keeping of records.
- Delivery of comprehensive Final Summary after completion of mock audit including commentary on each specific MU measure, review of Security Risk Analysis, including identified risks, vulnerabilities and areas for mitigation.

We also provide mitigation services post Mock Audit to address future CMS EHR Incentive audit inquiries.

Topic Resources

Contact us today at Inquiry@MeaningfulUseAudits.com.

Website: www.meaningfuluseaudits.com

Mock Audits: www.meaningfuluseaudits.com/meaningful-use-mock-audits

About Us: www.meaningfuluseaudits.com/us/

Disclaimer

Any content included in this document is presented for educational purposes only specific to the identified provider and specified CMS EHR Incentive attestation only. EMR Advocate, Inc. (EMRA) either directly or indirectly through speakers, independent contractors, employees or members of EMRA provides the Content as a service based on best practices and prior experience. EMRA does not represent or warrant that the documentation provided by EMRA could be interpreted in a different manner by other entities but is solely based on EMRA's knowledge as the date of the Content.

This information is not intended to be used to replace the advice of your own legal counsel. EMRA is the sole owner of the Contents. By using the Contents in any way, whether or not authorized, the user assumes all risk and hereby releases EMRA from any liability associated with the Content.