EHR Incentive Programs Appeals Overview

February 2016

Overview

CMS has an appeals process for eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) that participate in the Medicare Electronic Health Record (EHR) Incentive Program. States will implement appeals processes for the Medicaid EHR Incentive Program. Medicaid program participants should contact their State Medicaid Agency for more information about these appeals.

Providers that have met all Medicare EHR Incentive Program requirements, but were unable to register, attest, or as a result of an audit can file an appeal.

There are circumstances in which a provider may not appeal a decision made on an issue. As outlined in 42 CFR §495.110 "Preclusion on administrative and judicial review" appeal options are not available for the following:

- Incentive payment amounts or overpayment recoupment
- Selection or demonstration of meaningful use or clinical quality measures
- Payment adjustments
- Hardship exceptions
- Hardship reconsiderations
- Hospital-based determinations

Appeal reviews are typically completed within 60 days of appeal filed date.

Appeal determination letters are sent to the email address on the appeal filing request. Determination letters outline whether the appeal is upheld (favorable determination), denied (unfavorable determination) or dismissed (appeal was not eligible for review). If the appeal is denied, additional details on the denial are included in the determination letter. Appeal determinations are final and no further appeal options are available.

Appeal Types and Deadlines

The table below outlines the types of appeals, details for each appeal type, and deadlines for filing each appeal.

APPEAL TYPES	DETAILS AND DEADLINES
Failed Audit Meaningful Use Appeal	Allows a provider to demonstrate meaningful use by addressing each of the measures failed on audit. Appeals must be filed within 30 days after the adverse audit determination letter.
Failed Reporting Meaningful Use Appeal	Allows a provider to show that certified electronic health record technology (CEHRT) was used to successfully demonstrate meaningful use but failed due to a reporting issue. Appeals must be filed within 30 days after the attestation deadline.
CQM e-Reporting Meaningful Use Appeal	Allows a provider to show that Clinical Quality Measures (CQM) e-reporting was successful in meeting meaningful use. Appeals must be filed within 30 days after the attestation deadline.
Eligibility Appeal	Allows an EP to show that all EHR Incentive Program requirements were met and that the provider should have been able to register and attest for the Program but could not due to circumstances outside the provider's control. An example includes being unable to register by deadline. Appeals must be filed within 30 days after the attestation deadline.

Appeal Filing Request Forms and Instructions

To formally file an appeal, download the Appeal Filing Request and Instructions from the links below. Appeals must be filed by the applicable noted deadlines.

Eligible Hospital Appeal Filing Request Instructions
Eligible Hospital Appeal Filing Request
Eligible Professional Appeal Filing Request Instructions
Eligible Professional Appeal Filing Request

Appeal Documentation

All documentation is required at the time of submission and additional documentation will not be accepted. Electronic submission of this request is strongly recommended. CMS will only accept documentation submitted in Portable Document Format (.pdf), Microsoft Word Document (.doc), Microsoft Word Open XML Document (.docx) or Microsoft Excel spreadsheet (.xls) formats that are directly accessible through an email attachment. Methods for appeal submissions are outlined in the appeal filing request instructions. Documentation required for each appeal type:

Failed Audit Meaningful Use Appeal (Note: Documentation is required only for measures failed on audit)

- CEHRT proof of purchase (date, version number and provider information)
- Dated reports/screenshots from CEHRT that validate:
  - Core Measures and/or Exclusions
  - Menu Measures and/or Exclusions
  - Security risk analysis performed prior to the end of the reporting period
  - Patient list by condition from the EHR reporting period; patient-identifiable information (PII) should be masked before submission
  - A zero denominator for excluded measures and documentation justifying the exclusion
  - Documentation of a test submission to the registry or public health agency (whether successful or unsuccessful) that includes provider information
- Dated letter or email:
  - From immunization registry or public health agency confirming receipt, ongoing data submissions, date of submission and name of parties transmitting data
  - From vendor verifying CEHRT possession or other measures

Failed Reporting Meaningful Use Appeal

- Dated reports from provider's CEHRT that validate core and menu measures
- Detailed information related to the provider's inability to complete attestation by the deadline
- CEHRT proof of purchase (including date, version number and provider information)

CQM e-Reporting Meaningful Use Appeal

- Dated reports from provider's CEHRT that validate CQM submission
- CEHRT proof of purchase (including date, version number and provider information)

Eligibility Appeal

- Proof the Provider Enrollment Chain and Ownership System (PECOS) application was filed, including date of submission
- CEHRT proof of purchase (including date, version number and provider information)

Appeals Contractor Contact Information

Appeal inquiries and submissions can be sent to ehrappeals@provider-resources.com.

EHR Information Center Contact Information

The EHR Information Center is open to assist with registration and attestation system inquiries:
Phone: 1-888-734-6433* (primary number) *(press option 1) or 888-734-6563 (TTY number).

The EHR Information Center hours of operation are 7:30 a.m. – 6:30 p.m. (Central Time) Monday through Friday, except federal holidays.