Overview

Providers who receive an incentive payment for the Medicare or Medicaid Electronic Health Record (EHR) Incentive Program potentially may be subject to an audit. Eligible professionals (EPs), eligible hospitals, and critical access hospitals (CAHs) should retain ALL relevant supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses.

Documentation to support attestation data for meaningful use objectives and clinical quality measures should be retained for six years post-attestation. Documentation to support payment calculations (such as cost report data) should continue to follow the current documentation retention processes.

States and their contractors will perform audits on Medicaid providers. Please contact your State Medicaid Agency for more information about audits for Medicaid EHR Incentive Program payments.

Figliozzi and Company is the designated contractor performing audits on behalf of the Centers for Medicare & Medicaid Services (CMS), and will perform the audits on Medicare EPs and eligible hospitals, as well as on hospitals that are dually-eligible for both the Medicare and Medicaid EHR Incentive Programs. If you are selected for an audit you will receive a letter from Figliozzi and Company with the CMS and EHR Incentive Program logos on the letterhead.

Preparing and Maintaining Documentation

It is the provider's responsibility to maintain documentation that fully supports the meaningful use and clinical quality measure data submitted during attestation. To ensure you are prepared for a potential audit, save any electronic or paper documentation that supports your attestation. Also save the documentation that supports the values you entered in the Attestation Module for clinical quality measures. Hospitals should also maintain documentation that supports their payment calculations.

An audit may include a review of any of the documentation needed to support the information that was entered in the attestation. The level of the audit review may depend on a number of factors, and it is not possible to detail all supporting documents that may be requested as part of the audit. The following will outline the minimum supporting documentation that providers should maintain; however, the auditor may request additional documentation to substantiate the provider's attestation.

Source document(s)
The primary documentation that will be requested in all reviews is the source document(s) that the provider used when completing the attestation. This document should provide a summary of the data that supports the information entered during attestation. Ideally, this would be a report from the certified EHR system, but other documentation may be used if a report is not available or the information entered differs from the report.

Providers should retain a report from the certified EHR system to validate all clinical quality measure data entered during attestation, since all clinical quality measure data must be reported directly from the certified EHR system.

Providers who use a source document other than a report from the certified EHR system to attest to meaningful use data (e.g., non-clinical quality measure data) should retain all documentation that demonstrates how the data was accumulated and calculated.

This primary document will be the starting point of most reviews and should include, at minimum:

> ✓ The numerators and denominators for the measures
> ✓ The time period the report covers
> ✓ Evidence to support that it was generated for that EP, eligible hospital, or CAH (e.g., identified by National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc.)
> ✓ Evidence to support that the report was generated by the certified EHR system (e.g., screenshot of the report before it was printed from the system)

Because some certified EHR systems are unable to generate reports that limit the calculation of measures to a prior time period, CMS suggests that providers download and/or print a copy of the report used at the time of attestation for their records.

Although the summary document is the primary review step, there could be additional and more detailed reviews of any of the measures, including review of medical records and patient records. The provider should be able to provide documentation to support each measure to which he or she attested, including any exclusions claimed by the provider.

Documentation for Non-Percentage-Based Objectives
In addition, not all certified EHR systems currently track compliance for non-percentage-based meaningful use objectives. These objectives typically require a "Yes" attestation in order for a provider to be successful in meeting meaningful use. To validate provider attestation for these objectives, CMS and its contractor may request additional supporting documentation. A few examples of suggested documentation are listed below. Please note that the suggested documentation does not preclude CMS or its contractor from requesting additional information to validate attestation data.

Meaningful Use Objective	Audit Validation	Suggested Documentation
Clinical Decision Support Rule	Functionality is available, enabled, and active in the system for the duration of the EHR reporting period.	One or more screenshots from the certified EHR system that are dated during the EHR reporting period selected for attestation.

Meaningful Use Objective	Audit Validation	Suggested Documentation
Protect Patient Health Information	Security risk analysis of the certified EHR technology was performed prior to the date of attestation on an annual basis and for the certified EHR technology used during the EHR reporting period.	Report that documents the procedures performed during the analysis and the results. Report should be dated prior to the end of the reporting period and 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.). **Note:** The measure requires providers to address encryption/security of data stored in certified EHR technology.
Immunization Registry Reporting, Syndromic Surveillance Reporting, Specialized Registry Reporting and Electronic Reportable Laboratory Result Reporting (eligible hospitals and CAHs only)	Active engagement with a public health agency to submit electronic data from certified EHR technology for the EHR reporting period.	• 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. •

Meaningful Use Objective	Audit Validation	Suggested Documentation
Exclusions	Documentation to support each exclusion to a 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. For exclusions to public health reporting objectives, a letter, email, or screenshot from the registry that demonstrates the provider was unable to submit and would therefore qualify under one of the provided exclusions to the objective.
Alternate Exclusions and Specifications	Documentation to support each exclusion to a measure claimed by the provider.	CMS will not require documentation that a provider did not intend or plan to attest to a menu objective for the provider to claim the alternate exclusion.