EHR ADVISORY GROUP™

Preparing For an EHR Audit

By now, most medical practices have already wrestled with whether or not to start down the road of using an electronic health record system (EHR). The vast majority have decided to make the jump. Few however, really understood when starting out, all that is involved in staying on the EHR road including the need to meet three stages of Meaningful Use, the requirement to implement a patient portal and secure messaging and, of course, compliance audits.

We are now seeing significant numbers of EHR incentive audits which fall into two categories; pre- and post-payment. There is also a HIPAA type, which will be a subject for another time. The Centers of Medicare & Medicaid Services (CMS), the agency responsible for the EHR incentive program, has subcontracted the auditing initiative to Figliozzi and Company, an independent, national accounting firm. As would be expected, there are numerous audit checks built into the CMS system to detect inaccuracies in eligibility, reporting and payments. Audits will be random, as well as targeted when "suspicious or anomalous data" is detected. For both pre- and post-payment audits it is vital to provide supporting documentation to validate submitted attestation data. This information must be retained for six years.

According to CMS, the primary documentation that will be requested in all reviews is the source document(s) were used when completing an attestation. The most compelling form of documentation from CMS's perspective is that which comes directly from the Certified Technology (the EHR system). It is acceptable however, to use non-EHR generated data in some cases. To be on the safe side when doing so, it would be a good idea to consult with CMS first.

The starting point for EHR auditors most of the time is a report summarizing measure data that includes numerators and denominators, the time period of the report, and proof that it was generated for the specified eligible professional. Subsequent steps might also involve a more detailed assessment of information that supports the measures, including a review of patient records. The practice should be able to support each measure it has attested to as well as any exclusion claimed. It is critical that on the day of attestation, the practice makes copies of all reports utilized from the EHR and even screen shots where needed (this may be necessary for Clinical Quality Measure

data for some EHRs). It is also important that the Submission Receipt provided after a successful attestation on the CMS portal, is printed and saved.

For the measures that do not involve a percentage, CMS may request additional supporting documentation. Below is a CMS table with information that pertains to these measures:

Meaningful Use Objective	Audit Validation	Suggested Documentation
Drug-Drug/Drug-Allergy Interaction Checks and Clinical Decision Support	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.
Report ambulatory or hospital clinical quality measures	Clinical quality measure data is reported directly from certified EHR systems.	Report from the certified EHR system to validate all clinical quality measure data entered during attestation.
Protect Electronic Health Information	Security risk analysis of the certified EHR technology was performed prior to the end of the 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.)
Drug Formulary Checks	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.
Generate Lists of Patients by Specific Conditions	One report listing patients of the provider with a specific condition.	Report from the certified EHR system that is dated during the EHR reporting period selected for attestation. Patient-identifiable information may be masked/blurred before submission.
Immunization Registries Data Submission, Reportable Lab Results to Public Health Agencies, and Syndromic Surveillance Data Submission	One test of certified EHR technology's capacity to submit electronic data and follow-up submission if the test is successful.	• Dated screenshots from the EHR system that document a test submission to the registry or public health agency (successful or unsuccessful). 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 or unsuccessful 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 the receipt (or failure of receipt) of the submitted data, including the date of the submission, name of parties involved, and whether the test was successful.
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.

Preparing for an EHR audit well in advance of one occurring by maintaining an "audit book" with all the information mentioned above, as well as the reasons behind decisions the practice makes throughout the process, will stave off a great deal of worry and

concern by practice administrators. EHR audits will likely become just another aspect of running a medical practice in today's environment. Taking common sense steps should ensure all will go well if one actually occurs.

The EHR Advisory Group, LLC provides an array of EHR & Meaningful Use, as well as HIPAA privacy, security, breach and risk management services.

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