EHR Incentive Program Audit

MEDITECH's Recommendations and Guidance

CMS has contracted with Figliozzi and Company to conduct Meaningful Use audits of certified Electronic Health Record (EHR) technology. Letters have been sent to eligible providers and hospitals, who have received Stage 1 Meaningful Use incentive payments, requesting records related to attestation. The goal of the audit is to gather proof of everything healthcare organizations claimed when they applied for the CMS EHR Incentive Program.

Customers are responsible for completing the audit and providing documentation to Figliozzi and Company. We have reviewed the audit questions and provided information to assist MEDITECH Eligible Hospitals when responding to the EHR Incentive Program Audit (see below). **6.0**, **Client/Server**, and **MAGIC** customers should refer to the G*uidance to MIS Dictionary Audit Logs for Meaningful Use Audit* document for specific MIS Dictionary setup instructions. We've also posted commonly asked audit questions and responses on our **ARRA FAQ** page. We've also included a "lessons learned" section from customers who have been previously audited. Additionally, CMS has posted guidance documents for the audit requirements, which are included at the end of this document. Eligible Providers, please see the **6.0**, **Client/Server**, and **MAGIC** *Meaningful Use Audit Guide for Eligible Professionals* document for information concerning audits.

We are monitoring the emerging audit requirements closely and alerting our customers when we learn of new requirements from the audit process. Our HCIS Coordinators are ready to help your organization with this effort, please contact them for assistance.

Audit Questions and Answers

PART I - GENERAL INFORMATION

1. **As proof of possession of a certified Electronic Health Record technology system, provide a copy of the Office of the National Coordinator of Health Information Technology (ONC) certification as well as licensing agreements with the vendor or invoices from the time the system was purchased.**

   For proof of Certification, please visit **MEDITECH's Certification Resource Page** to download a copy of the Office of the National Coordinator of Health Information Technology (ONC) certification document(s). Upon request, MEDITECH will provide you with a letter regarding your licensing agreements. Please contact your HCIS Coordinator or Marketing Consultant.

2. **Provide the documentation to support the method (Observation Services or All ED Visits) chosen to report Emergency Department (ED) admissions designating how patients admitted to the ED were included in the denominators of certain Meaningful Use core and menu measures (i.e. an explanation of how the ED admissions were calculated and a summary of ED admissions).**

   MEDITECH provides Report Writer, Report Designer, and SQL report templates that contain logic to calculate the Observation Services method. Customers may choose the All ED Visits method, which requires additional changes to the report. Customers should document which method was used when producing the reports. The reports can be printed as a summary or include patient detail. We advise our customers to create detailed versions of the reports and save the output in the event of an audit.

   For Report Writer reports, MEDITECH provides a technical doc for each report which states: *This report selects patients based on the Observation Services method. If your organization opts to use the All ED Visits method, the status macro needs to be edited to remove the ";" in front of the code /STATUS["ER"]. After editing the macro, the user needs to translate the report using the number four (4) translate from the Process Reports Menu.*

   For Report Designer reports, MEDITECH provides a technical document for each report which

states: *This report selects patients based on the Observation Services method. If your site opts to use the All ED Visits method, the status rule MTREGTYPE needs to be edited. This rule is attached to the c_field of c_regtype. To edit the rule go to the rule's logic and highlight line # 4. Click on the Move Up button at the bottom of the screen. File the rule with this change and your report will use the ALL ED Visits method.*

In the SQL reports, there are comments in the code to enable or disable the ALL ED Visits method:

/ Remove Comment Below for All ED Method */*
--OR AD.PtStatus = 'ER'

Consistent with CMS Audit Guideline Supporting documentation, a screenshot depicting the code edit to enable or disable the ALL ED Visits method should satisfy this audit request.

PART II - CORE SET OBJECTIVES/MEASURES

3. **Provide the supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses (i.e. a report from your EHR system that ties to your attestation). Please Note: If you are providing a summary report from your EHR system as support for your numerators/denominators, please ensure that we can identify that report has actually been generated by your EHR (i.e. your EHR logo is displayed on the report, or step-by-step screenshots, which demonstrate how the report is generated by your EHR are provided.) To support Y/N attestation measures, please supply documentation such as screenshots from your EHR system.**

MEDITECH provides Report Writer, Report Designer, and SQL report templates that enable your organization to calculate the Meaningful Use functional measures as defined in MEDITECH's Best Practice documentation. The reports can be printed as a summary or include patient detail. We advise our customers to detail versions of the reports and save the output in the event of an audit. We also advise our customers to save a copy of the version of the best practice document used through the reporting period along with the best practice change log. Please visit our ARRA Best Practices web area on our **Regulatory page** for more information.

Numerator/Denominator Attestation Measures

In all platforms, MEDITECH software contains a help menu at the top of the application window which contains the MEDITECH copyright, which can be captured in the foreground of a Report Writer or Report Designer report execution window. For Client/Server Report Writer or Report Designer, screenshots of the report execution routine will include the MEDITECH logo at the top left corner of the window. Additionally, screenshots of the MEDITECH Document Manager output contains the words "MEDITECH Document" in the window title bar. For MAGIC Report Writer, screenshots of the report execution routine will include the MAGIC Workstation MEDITECH logo at the top left corner of the window. For SQL reports, the MEDITECH logo cannot be presented from SQL, however the MEDITECH SQL database and tables are proprietary to our software. The suggested process is as follows:

1. Screenshot MEDITECH Data Repository Parameters routine showing the target SQL database (livedb, liveNdb, liveATdb, etc).

2. In SQL management studio, open each report and run it in the target database. Screenshot the output and ensure the target database is visible at the top of the management studio window.

Y/N Attestation Measures

Screenshots consistent with the CMS guidelines of settings or parameters that support the measure should satisfy the audit request.

PART III - MENU SET OBJECTIVES/MEASURES

4. **Provide the supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses (i.e. a report from your EHR system that**

ties to your attestation). Please Note: If you are providing a summary report from your EHR system as support for your numerators/denominators, please ensure that we can identify that report has actually been generated by your EHR (i.e. your EHR logo is displayed on the report, or step-by-step screenshots, which demonstrate how the report is generated by your EHR are provided.) To support Y/N attestation measures, please supply documentation such as screenshots from your EHR system.

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Y/N Attestation Measures
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Lessons Learned

Here we've provided some of the common "lessons learned" from customers that have been previously audited:

- Expect 3 to 4 rounds of requests for information from the auditors.

- Make sure your Security and Risk Analysis is performed during your reporting period and at the time the Security and Risk Analysis should be performed each year you are reporting. Complete documentation of the Security and Risk Analysis will be needed. Please read the **Top 10 Myths of Security Risk Analysis** from the HealthIT.gov website for common myths about Security Risk Analysis.

- The Yes/No responses will be scrutinized. Any source of various types of documentation should be kept: audit logs, screencaps of parameters and actual D/D, D/A interventions taking place (at least one) during the reporting period may help (ensure the screencaps are date stamped). An example of proving that Drug-Drug and Drug-Allergy checking took place could be accomplished by including screenshots of Pharmacy Print Orders for orders entered during the reporting period. This would demonstrate the interaction warnings that took place since the start date of the order, as well as the date the interaction check took place is

included on the Pharmacy Print Order.

- Reports should be run for short time period at the beginning of your reporting period to allow for validation of data. Report and workflow validation should take place in the LIVE environment at least 30 days prior to the beginning of the reporting period. 8 Reports have the same denominator, these should also be checked to ensure that these match:
    - Problem List - Stage 1
    - Medication List - Stage 1
    - Medication Allergy List - Stage 1
    - Record Demographics - Stage 1 & Stage 2
    - Vital Signs, BMI, Growth Charts - Stage 1 & Stage 2
    - Patient Education - Stage 1 & Stage 2
    - Electronic Notes - Stage 2
    - Family History - Stage 2

  At a minimum, you should run the reports for 30, 60, 90, 180, 365 day periods (to keep track of where you are in terms of thresholds) and print/save off the copies.

- For any of the public health objectives please retain letters and emails 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. Also, any dated screenshots from the EHR system that document a 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. For example, National Provider Identifier (NPI), CMS Certification Number (CCN), provider name, practice name, etc. From your MEDITECH EHR, this can be taken from our interface manager and a screenshot of the message status (SENT, FAIL, etc). Further documentation could be printed through the Outbox Message report which has date/time stamp, as well as hospital/database headers to prove this was from your MEDITECH EHR.

- Print/save other information such as certification letter, screenshots, etc.

- Ensure that you have a validated and documented process for disaster recovery. Ensure that you have clean backups in case of hardware failure, etc.

- Confirm that there are at least two members of your Meaningful Use team that understand all of the measures, reports, validation information, selection of menu items, and information related to attestation and that the information is accessible in one place.

- Please ensure that your Meaningful Use contact (that was provided to CMS during your attestation process) is still currently working at your facility, as their contact information will be used for any ensuing Audit emails and letters.

CMS Guidance Documents

Here we've provided the audit requirements documents posted on the CMS website. We recommend reading each of these documents:

- **CMS Frequently Asked Questions**
- **CMS Audit Overview Fact Sheet**
- **CMS Audit Supporting Documentation.**