MEANINGFUL USE BEST PRACTICES
Independent Mock Audit of Annual Attestations
Title: Meaningful Use Best Practices: Independent Mock Audit of Annual Attestations

Description: This presentation will discuss Meaningful Use Audit, from the perspective of an auditor. We will also present best practices for evaluating provider attestation (pre-submission) against the potential of being selected for CMS audit, and what are the characteristics of documentation most likely to provide a sound audit defense. We will also discuss mock audit, from engaging independent third parties, to the creation of strategies that enable internal audit teams to effectively deliver mock audit.
MU COORDINATOR HAS A COMPLEX JOB

Coordinate CMS Audits
Plan Audit Appeals
Analyze Regulations for configuration and workflow changes.
Run Meaningful Use Reporting from EHR
Share results of Security Risk Assessment
Manage PECOS Proxies
Register EP’s in PECOS
Receive initial audit request
Obtain prior employer MU Documentation
For current and prior years
Clarify responsibilities for failed audit (with Providers new to the practice)
Arrange and document Existence of correct CEHRT
Post MU Payments From Medicare and Medicaid
Track expected Stimulus and Penalty data
Mock Audit (manage Or conduct)
Test and sustain Public Health Connectivity Proof
Execute Quality Reports
Evaluate individual provider CQM Compliance
Internal Audit
Data Communications
Quality Reporting
CFO
IT Analyst
IT Security
Financial Manager
CIO
Revenue Cycle Staff
Physician Contracting
MU COORDINATOR MANAGES MOUNTAINS OF DATA

Meaningful Use Quantitative Measures: 11–13 per EP, per report cycle

Analyze Regulations for configuration and workflow changes: A few hundred pages of Federal Register per year, plus 300+ FAQ’s

Annual Audits: One per 20 EP’s (on average)

Security Risk Assessment: one per location per year

Audits Body of Evidence: 2-3 documents per Measure per EP

PECOS Registrations: One per EP

Public Health Connectivity Proof: One per Public Health Measure, Per EHR Per Public Health Jurisdiction

Meaningful Use Payments: One per EP per reporting year

Execute Quality Reports: 9 Per EP across 3 domains, but ...

Arrange and document Existence of correct CEHRT: One per major EHR Release

Most organizations run 20+ CQM’s To assure coverage

For a population of 60 EP’s, one MU Coordinator manages over 4,000 elements of information
MU COORDINATOR MANAGES AN EVOLVING (SOMETIMES REVOLVING) POSITION

Office Manager With Meaningful Use Responsibilities

Original Dedicated Meaningful Use Coordinator

Meaningful Use Startup Consultant

Replacement Meaningful Use Coordinator
Why is MU a risk conversation?

Adverse Audit = Unpleasant Surprise

- Hospital audits have potential large single impact (6 or 7 digit recoupment plus penalty)
- Physician audits financial impact is less but document management is large

Most likely audit failure is inadequate documentation, rather than lack of compliance

- Created outside the reporting period / cannot reproduce exact attestation results
- Missing EHR system logo and/or hospital/clinic identification
- Create audit error because documentation is not self explanatory
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.
CMS Audits may not be rigorous enough

- Reports from certified EHR technology are not sufficient for CMS to verify self-reported information and may not always be accurate.

- CMS cannot use EHR reports to verify all self-reported meaningful use information because ONC does not require certified EHR technology to be capable of producing reports for all meaningful use measures. ONC requires only that certified EHR technology be capable of producing reports covering professionals' and hospitals' performance on the 30 percentage-based meaningful use measures. ONC does not require certified EHR technology to be capable of producing reports for the 19 yes/no measures.

The Standard for Audit Documentation is Higher than the Standard for Software Certification
CMS MAY BE DROPPING THE BALL WITH INADEQUATE OVERSITE

WHAT WE FOUND
CMS faces obstacles to overseeing the Medicare EHR incentive program that leave the program vulnerable to paying incentives to professionals and hospitals that do not fully meet the meaningful use requirements. Currently, CMS has not implemented strong prepayment safeguards, and its ability to safeguard incentive payments postpayment is also limited.

The Standard for Audit Documentation is Higher than the Standard for Software Certification
CEHRT DOES NOT NATIVELY PROVIDE ALL “PROOF”

Table 2: CMS’s Assessment of Data Sources To Verify the Accuracy of Self-Reported Meaningful Use Information

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Number of Meaningful Use Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal CMS data sources are accessible but not comprehensive enough for verification (e.g., Medicare claims data).</td>
<td>25</td>
</tr>
<tr>
<td>External data sources are not accessible for verification (e.g., privately held e-prescribing data, State public health agency data).</td>
<td>6</td>
</tr>
<tr>
<td>No data source exists (i.e., data for measure are not currently collected by any entity).</td>
<td>19</td>
</tr>
<tr>
<td>Internal CMS data sources and external data sources exist but are not comprehensive or accessible for verification, respectively.</td>
<td>(1)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>49</strong></td>
</tr>
</tbody>
</table>


HPS Observation:

If you were CMS, how would you respond?

What compensations can we expect CMS to direct their auditors to employ?

The Standard for Audit Documentation is Higher than the Standard for Software Certification
No one knows for sure, but ...

Audit Red Flag

General Reasonableness check between measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>&lt;= Unique Patients</th>
<th>Relationship to CPOE</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPOE for Medication Orders</td>
<td>X</td>
<td>N/A</td>
</tr>
<tr>
<td>Record Vital Signs</td>
<td>X</td>
<td>&gt;=</td>
</tr>
<tr>
<td>Electronic Copy of Health Information</td>
<td>X</td>
<td>&lt;</td>
</tr>
<tr>
<td>Electronic Copy of Discharge Instructions</td>
<td>X</td>
<td>&lt;</td>
</tr>
<tr>
<td>Advance Directives</td>
<td>X</td>
<td>&lt;</td>
</tr>
<tr>
<td>Incorporate clinical lab test results into EHR</td>
<td></td>
<td>&gt;</td>
</tr>
<tr>
<td>Generate Patient Lists</td>
<td>X</td>
<td>&lt;</td>
</tr>
<tr>
<td>Perform Medication Reconciliation</td>
<td>X</td>
<td>&lt;</td>
</tr>
<tr>
<td>Send transition of Care Record</td>
<td>X</td>
<td>&lt;</td>
</tr>
</tbody>
</table>

Deploy scarce resources on providers deemed most likely to have received inappropriate payments:

- CEHRT Inadequacies
- SRA Shortfalls
- Content within the Attestation
AUDIT PROCESSES – WHAT ARE AUDITORS REQUESTING?

• Numerator / Denominator based Measures:
  - Certified EHR Software Reporting
  - Detail Patient Logs
  - Policy / Procedure / Workflows

• Supplemental Documentation on Non-Percentage Items
  - Screen Shots, System Configuration Documentation
  - Patient logs showing alert was fired
  - Testing results

• Proof of EHR Ownership

• Patient Volume Documentation
  - Validate Medicare / Medicaid patient Mix
  - Comparison for measures requiring “Non-EHR” patients
Best Practices for CMS EHR Incentive Appeals

• When in doubt, always appeal
• Last chance to be successful
• Since the audit was failed you need to change direction
• Opportunity to make your case with additional documentation and explanation
• Keep it simple and focused
A well-constructed Mock Audit

• Independent Review – not the MU Coordinator
  ▪ Internal Audit needs some help, but can do the job
  ▪ Third Party should provide tools, training and transparent processes

• Start with Documentation Strategy
  ▪ Certified reports are required in every audit
  ▪ Auditors like details and you may not be able to reproduce history indefinitely
  ▪ Include workflow (or policy) because reports don’t prove all aspects of compliance

• Mirror Figliozzi processes, with Exceptions
  ▪ It is all about documentation
  ▪ You don’t need a lot of interviews
  ▪ You need to prepare all possible details – CMS can pick and choose
  ▪ Not like Joint Commission (you can’t mediate the past)
  ▪ Balance risk with cost of compliance

• Prepare for the Real Audit – Get it in the Database!
  ▪ Mock audit results should explicitly build your Book of Evidence, not simply comment on it
  ▪ Save notes and explanations
  ▪ Don’t rely on your memory. You may not be the person responding to a future audit
AUDIT DOCUMENTATION – WHEN DO I CREATE IT?

• During Reporting Period
  ▪ Screen Shots showing capabilities were enabled
  ▪ Almost all “Yes / No” measures

• Shortly After Reporting Period
  ▪ Summary Measure Reports from the EHR
  ▪ Details supporting summary reports from the EHR
  ▪ Caution: Vendors are not required by Certification Standards to provide these, but you may be required to present them to an auditor!

• At Any Time During the Year
  ▪ Security Risk Assessment
  ▪ Public Health Connectivity
  ▪ Policy and Work flow asserting compliant processes and configurations

• Before Reporting Period
  ▪ Proof of Complete CEHRT Ownership
  ▪ Adding modules to existing complete is ok. Adding modules to make complete is not.
  ▪ Change of CEHRT during period is possible but generates double documentation work
STRATIFY YOUR ANALYSIS OF RESULTS

Inability to document vs. Actual non-compliance

*In our opinion, [Client Name] is at risk of failing an audit of 2012 Meaningful Use Reporting year.*

- **Red shortfalls** are indicators of potential non-compliance (1)
  - Ownership of complete Certified EHR Technology
  - Only one Red shortfall was identified

- **Yellow shortfalls** are indicators of inadequate documentation which, if reviewed by an auditor could fail to show proof of compliance (15)
  - Patient level of detail does not clearly support attested values
  - Identification of “all patients, regardless of whether records are maintained in CEHRT” does not exist.
  - Screen shots for yes/no measures missing clear proof that they were taken during the reporting period, or that they were taken from [Client Name] CEHRT.
## Yellow: Documentation Shortfalls

<table>
<thead>
<tr>
<th>Req ID</th>
<th>Requirement Short Name</th>
<th>Departments</th>
<th>Status Indicator</th>
<th>EHR</th>
<th>Responsible Person(s)</th>
<th>Detail Patient Log</th>
<th>Certified EHR Report</th>
<th>Policy Procedure Link</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2015-05-27: Departmental sort / subtotal make log excessively difficult to use as a validation tool; see Documentation Recommendations for detail patient log. Regulations require this measure to count all patients in POS 21 and 23, regardless of whether their records are maintained in CEHRT. Auditors will request verification of total patient volume during the reporting period, to compare with total patient volume maintained in the CEHRT. If patient records exist outside the CEHRT, then the denominator for this measure must be increased to account for those non-EHR patients. Documentation provided does not indicate whether such patients existed. Note that a more assertion that no patients are maintained outside the EHR, would not be sufficient audit proof. Policy statement supports the measure 5/13/14 loaded new detailed patient log.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2015-05-27: Departmental sort / subtotal make log excessively difficult to use as a validation tool; see Documentation Recommendations for detail patient log. Regulations require this measure to count all patients in POS 21 and 23, regardless of whether their records are maintained in CEHRT. Auditors will request verification of total patient volume during the reporting period, to compare with total patient volume maintained in the CEHRT. If patient records exist outside the CEHRT, then the denominator for this measure must be increased to account for those non-EHR patients. Documentation provided does not indicate whether such patients existed. Note that a more assertion that no patients are maintained outside the EHR, would not be sufficient audit proof. Workflow documentation shows Epic capabilities, but shows no indication that it has been adopted by Kadlec (i.e., hospital name on the form), nor that it was in effect during the reporting period. 5/13/14 loaded new detailed patient log.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2015-05-27: Departmental sort / subtotal make log excessively difficult to use as a validation tool; see Documentation Recommendations for detail patient log. Workflow documentation does not show a process to capture vital signs defined by this measure, nor does it show any indication that it has been adopted by Kadlec (i.e., hospital name on the form), nor that it was in effect during the reporting period. 5/13/14 loaded new detailed patient log.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>2015-05-27: Departmental sort / subtotal make log excessively difficult to use as a validation tool; see Documentation Recommendations for detail patient log. Policy statement supports the measure but could be improved by explicitly mentioning Kadlec’s EHR (current reference is to &quot;Care Manager&quot;) 5/13/14 loaded new detailed patient log.</td>
</tr>
</tbody>
</table>

Copyright ©HighPoint Solutions, LLC. All Rights Reserved. Unauthorized Distribution or Duplication Prohibited.
Audit processes vary from one provider to another, regarding:

- What criteria are selected to be audited
- What documentation is requested for each criterion
- Whether the audit will be conducted onsite, or remotely

CMS can vary audit objectives, rigor, and probability regularly, and has committed to Congress to re-evaluate audit programs quarterly to verify that audits are meeting Congressional goals.

Some audits are exhaustive of all criteria.

Laws, regulations, and CMS published guidance gives auditors the right to be rigorous. It is not possible to predict with great accuracy what will be the standards applied to audits over the next several years. Prudent providers should assemble documentation assuming the most rigorous standards possible under the law.
Spreadsheets and other Ad-Hoc Tools are not a Best Practice for permanent programs

Dedicated software tools emerging

Internal development is an option if you have the manpower

Tools support more than simple compliance
  - Automated Attestation
  - Support Mock Audit by enabling your Internal Audit teams with content knowledge
  - Organize Historical data not managed by EHR (especially for physicians)

**MUM or Meaningful Use Monitor** is a cloud-based product by C3 Partners, LLC. It supports ambulatory and inpatient domains, and is supported by Meaningful Use Help Desk, an educational portal, and mock audits associated with each subscription. The URL is MeaningfulUseMonitor.com, and its Help Desk site is MeaningfulUse.Guru.

**SA-Ignite** markets a product called MU Assistant, originally deployed and used by a number of Regional Extension Centers (RECs) for small physician practices, and is oriented toward Eligible Professionals. The URL is SAIgnite.com.

**Iatric** has a product based on its strong Meditech relationships, primarily in hospitals. Their Meaningful Use Manager is typically installed on-site, and has the benefit of reproducing Meaningful Use reporting that is typically weak in Meditech installations.
Meaningful Use Attestation is Required at least through 2021

Audit Retention Cycles through at least 2027

CMS develops Regulations in support of Legislation
  - Regulation subject to administrative change
  - Audit standards are regulatory, not legislative
  - Current Administration created the Stimulus and Audit program
  - Current auditors do not dig as deeply as their rights allow

Prudence means preparing for what auditors are permitted to review
THANK YOU!

Copy the following link for a free e-Book on today’s concepts

http://meaningfulusemonitor.com/HighPoint.html