Surviving a Meaningful Use Audit: Useful Tips from an Actual Survivor

Presented By:
Wendy Wright, CHC, CHPC, CPC, CPMA, CEMC
Corporate Compliance Officer, CaroMont Health

Lauren Wright, RN, MSN
Director, Quality and Care Coordination, CaroMont Medical Group

Wendy Wright Bio
18 years experience in healthcare
Certified in Healthcare Compliance and Privacy Compliance with the HCCA
Certified in Coding, Auditing and Evaluation and Management Coding with the AAPC
10 years of experience in Healthcare Compliance
Newly appointed Compliance Officer

Lauren Wright Bio
Director, Quality and Care Coordination, CaroMont Medical Group
Registered Nurse, Master’s of Science in Nursing Education (MSN)
Over 14 years experience in healthcare
Experience emphasis
- 4 years experience in healthcare quality
- Patient care nursing
- Care Coordination
- Leadership
### Disclaimer

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### Questions

What initial questions do you have about meaningful use, and meaningful use audits?

### Objectives

- Our Meaningful Use Audit Story
- Background of Meaningful Use
- Preparing for a Meaningful Use Audit
- The ABCs of an Actual Meaningful Use Audit
- Common Audit Findings
- Compliance Risks of Meaningful Use
- Appealing Unfavorable Results
- Takeaways
About CaroMont Health

• CaroMont Regional Medical Center, 435 beds
• CaroMont Medical Group, a network of 45 primary & specialty physician offices in 5 counties and 2 states
• Courtland Terrace, 96 bed skilled nursing facility
• Gaston Hospice, Robin Johnson House, 19 bed Inpatient Hospice House

What is Meaningful Use?

The American Recovery and Reinvestment Act of 2009 specifies three main components of Meaningful Use:
1. The use of a certified EHR in a meaningful manner, such as e-prescribing medications for safety and efficiency.
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care.
3. The use of certified EHR technology to submit clinical quality and reduce health disparities.

Simply put, "meaningful use" means eligible professionals, and eligible hospitals, need to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity.

Oversight of Meaningful Use

• Health Information Technology for Economic and Clinical Health Act (HITECH)
• Office of the National Coordinator of Health IT
• Centers for Medicare and Medicaid Services (CMS)
Who is Eligible for Incentives

- Under Medicare Meaningful Use – Physicians
  - MDs
  - DOs,
  - Dental Surgeons and Doctors of Dental Medicine
  - Optometrists
  - Chiropractors

- Under Medicaid Meaningful Use – Providers
  - Physicians
  - Midlevel Providers – NPs, PAs, CNM
  - Dentists

Stages of Meaningful Use

- Stage 1
  - Data collection and sharing
  - 13 Core Objectives (started CY 14)
  - 5 of 9 Menu Objectives

- Stage 2
  - Advanced clinical processes
  - 17 Core Objectives
  - 3 of 6 Menu Objectives

- Stage 3
  - Improved outcomes

Incentives/Penalties

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<thead>
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<th>Year</th>
<th>Medicare Incentives/Penalties</th>
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<tr>
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<td>Maximum Benefit per Provider using EHR (if applicable), if 100% of CY 14 and CY 15</td>
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<tr>
<td></td>
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<td>First year</td>
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<td>Beyond</td>
<td>Beyond 2% CaroMont Health, 2016</td>
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Encouraging providers to participate and follow evidenced based care and medical home model of care.
How to get past the $$$$$$?

We have a theory in CaroMont Quality.

There are 3 things you DO NOT do to providers: (1) mess with their money, (2) mess with their call schedule, and (3) do not abuse their time.

What you SHOULD do is appeal to what they do to impact high quality patient care and their ability to provide low cost care to the patient. They do this daily, and likely just need to understand the meaning behind the words.

Preparing for a Meaningful Use Audit

- Continued State of Readiness
  Task Force Deployment

- Who is Figliozzi?
  CMS awarded Figliozzi and Company, CPAs the contract to conduct Medicare Meaningful Use audits.

- How will I know if I am being audited?
  All audit notification for providers within our organization were sent to the provider’s business email address that was used for the registration/attestation process. This includes providers that may no longer be with your organization!

The ABCs of an Audit

- Provider receives notification email and documentation request
- Provider given 30 days to submit documentation
- Documentation can be submitted via Figliozzi portal or sent certified mail or package delivery service
- Initial review of documentation by Figliozzi representatives; may be asked for additional information
- Outcome notification via email
The ABCs of an Audit

Helpful Tips

- Ensure all providers check their email regularly and notify the appropriate person immediately when audit notification received.

- If possible, implement email filters to “catch” emails from auditors

Audit Types

Two Types of Audits:

- Pre-Payment (before incentive monies are paid)
- Post-Payment (after incentive monies are paid)

Depending on your organizational structure for payment, post payments can be more challenging – money will have to be paid back to CMS if audit final decision is not supportive of attestation.

Audit Notification Email

This is an example of an actual audit notification email. Note email date of 11-5-13, deadline of 12-3-13.
Two types of documentation requests:

Full Documentation:
- Copy of CEHRT licensing agreement
- Core Measure Report/Supporting documentation
- Proof of Security Risk Assessment
- Menu Measure Report/Supporting documentation
- Information on all locations provider may have patient encounters, even if outside your organization.

Limited Documentation:
- Copy of CEHRT licensing agreement
- Core Measure Report/Supporting documentation
- Proof of Security Risk Assessment
- Menu Measure Report/Supporting documentation

It is important to be aware of all locations your providers may be practicing – even if outside your organization.

Full documentation requests require:
- Listing of each office or outpatient facility where the provider sees patients
- If each office/outpatient facility uses CEHRT
- If provider sees patients at more than one office/outpatient facility, documentation that proves 50% or more of patient encounters during EHR reporting period were conducted using CEHRT
- If provider maintains records outside of CEHRT, documentation more than 80% of medical records for unique patients seen during attestation period are maintained in CEHRT at each office/outpatient facility.
Gathering Data and Documentation

You are given 30 days to submit all requested documentation. It is imperative to work quickly and efficiently once email notification received.

Helpful Hint:
Implement a “Ready, Set, Go” that outlines your process and appropriate persons to notify within the organization.

Ready, Set, Go

1. Information Technology (IT) runs email filters.
2. Email received. The organization has been trained “audits” are forwarded to key personnel.
3. The Quality team notifies the MU workgroup members.
4. The Quality Team contacts the provider and has them send an email to the Quality Team (following script) that the team then forwards to the auditor allowing permission to work on the provider's behalf.
5. Register the quality team key role staff to access the providers portal.
6. An email is sent to the provider about registering-No action needed on their part.
7. Required audit documentation is submitted to portal.

What if Your Data Does Not Represent What You Thought it Did?

Just like the old saying, “If you didn’t document it, you didn’t do it”

Helpful Hints:
• Save all attestation reports and receipts
• Do not rely on your EHR vendor to produce historical reports
• Ensure your Security Risk Assessments are documented
• Save all associated reports (patient lists, etc)
Overcoming Obstacles Known or Unknown

- Security Risk Assessments: On or before your attestation

There is no clear guideline from CMS on when to conduct, but general rule is one SRA per calendar year of program, and must be done before the end of the attestation date range.

Common Audit Findings

- Frequency of Security Risk Assessments
  - Meaningful Use requires annually
  - HIPAA only requires every 2 years
- Security Risk Analysis not meeting the requirements
  - Specific to the practice
  - Completed before the end of the reporting period.
- Lack of Documentation
  - Reports must show measure compliance
  - Screen shots are acceptable

Interaction with Auditors

- Website
- Extensions
- Requests
- Auditors unable to see uploaded data
- Sending certified mail
### Risk and Impact to Organization

We call it “Stranger Danger”!

As Meaningful Use eligible professionals are now subject to penalties, it is important to assess potential negative financial impact a provider may bring when on-boarding with a new organization.

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### Compliance Risks

- **Provider Attestations**
  - True and Accurate
- **Potential for False Claim**
  - False Statement = False Claim
- **Incentive Payment Recoupment**
  - Documentation, Documentation, Documentation

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### Appealing Audit Results

- **Unfavorable Medicare Audit Results**
  - Complete the Eligible Professional Appeal Filing Request
  - 30 days of the audit determination
  - All documentation must be submitted to support the appeal.

- **Unfavorable Medicaid Audit Results**
  - Handled at State Level
  - Contact State Medicaid Agency
Take Away Points

- Know which email address used for MU
- Check emails, implement filters
- Develop protocol/procedures for audit process
- Document, document, document!
- Save all reports/attestation materials
- Read/Review any materials/letters/reports produced by EHR vendor
- Don’t rely on EHR vendor to produce!
- Conduct regular SRA’s and document date, findings, and actions
- Follow up with Figliozzi to ensure documentation received!

Helpful Resources


Additional Questions
Contact Information

Wendy Wright
wendy.wright@caromonthearchalth.org
704-671-5304

Lauren Wright
lauren.wright@caromonthearchalth.org
704-671-5325