Navigating a Meaningful Use Audit: Are You Ready?

Brian Flood

2014
Agenda For This Segment

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2. What is Meaningful Use?
3. Progress to Date
4. How providers meet Meaningful Use
5. Meaningful Use Audits
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ARRA, HITECH, and “Meaningful Use”

- The Health Information Technology for Economic and Clinical Health (HITECH) Act was enacted as part of the American Recovery and Reinvestment Act of 2009 (ARRA).

- The HITECH Act includes more than $19 billion to help develop a robust IT infrastructure and data exchange capabilities for healthcare, as well as to assist providers in adopting and using Health Information Technology, including the implementation of Electronic Health Records (EHRs).

- The Medicare and Medicaid EHR Incentive Program, a.k.a. “Meaningful Use” is born!

*The goal of this program is to increase EHR adoption, and support the “meaningful use” of EHR technology in order to improve safety, quality and reduce the cost of care.*
ARRA, HITECH, and “Meaningful Use”

Yes, there are incentives!

- Eligible Hospitals (EHs) can receive several million in incentives (dependent upon various factors).

- Eligible Professionals (EPs) can receive up to $44k under Medicare or up to $63,750 under Medicaid.
The term “Meaningful Use” means that providers need to show they're using certified EHR technology in ways that can be measured significantly in quality and in quantity.

- Stage 1 (2011) sets the baseline for electronic data capture and information sharing using EHRs.
- Stage 2 (2014) focuses on data sharing, patient engagement, and Health Information Exchange.
  - Eligible Hospitals can begin reporting period in October 2013
  - Eligible Professionals can begin reporting period in January 2014
- Stage 3 (expected to begin in 2016) will continue to expand on previous baselines to improve clinical outcomes.
“Meaningful Use” (cont'd)

What do EP’s and EH’s have to do?

It's not enough just to own a certified EHR. Providers have to show CMS that they are using their EHRs in ways that can positively affect the care of their patients. To do this, providers must meet objectives established by CMS. Then they will be able to demonstrate, or “attest” that they met the applicable measures.

- EPs and EHs must meet all “Core Set” Objectives to successfully attest to Meaningful Use. Some core objectives have exclusions that can be taken, which indicates that the EP or EH does not have to actually meet that objective, based on a particular circumstance or exception.

- EPs and EHs must also meet a specified number of “Menu Set” Objectives (varies by EP/EH and MU stage).
Most objectives are based on how the EHR is used for patient care

- E.g., “More than 30% of unique patients with at least one medication in their medication list seen by the EP or admitted to the eligible hospital’s or CAH’s inpatient or emergency department have at least one medication order entered using CPOE.”

However there are other measures related to data sharing

- E.g., Public Health objectives where EPs/EHs have to prove they have the ability to send data to various Public Health agencies (e.g., immunization data to state immunization registries).

One measure is related to security of patient information

- “Conduct or review a security risk analysis in accordance with the requirements under 45 CFR 164.308(a)(1) and implement security updates as necessary and correct identified security deficiencies as part of its risk management process.”

Measures are generally “Yes/No” or “Percentage-based”
Meaningful Use: Progress to Date

From a CMS Fact Sheet, released 4/23/2013:

- **Hospital Participation**: More than 85% of eligible hospitals are participating in the Medicare and Medicaid EHR Incentive Programs, and **more than 75% have received incentive payments for meaningfully using EHR technology**.

- **Physicians and other Health Care Provider Participation**: More than 388,000 of the nation’s eligible professionals have registered to participate in the Medicare and Medicaid EHR Incentive Programs, representing 73% of all providers eligible to participate. **More than 230,000, or 44% of all eligible professionals, have received an EHR incentive payment for meaningfully using EHR technology**.
In For A Penny In For A Pound

- Any provider attesting to receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Program potentially can be subject to an audit. Here is what you need to know to make sure you are prepared.
Meaningful Use Audits

Audits

In early 2012, the U.S. Government Accountability Office (GAO) looked at steps taken by the federal government and the states to verify participants meet criteria for receiving payments and are putting computerized information to “meaningful use.”

“The EHR programs may be at greater risk of improper payments than other, more established CMS programs because they are new programs with complex requirements that providers must meet to qualify for incentive payments.”

Robert Anthony—Deputy Director of CMS’s Health IT Initiatives Group—said that CMS aims to audit about 5% of all meaningful use program participants.

- CMS will look to conduct the same amount of pre-payment audits and post-payment audits;
- A majority of these will be via “desk audits,” but on-site audits could occur; and
- Other sources have numbers as high as 10% for EHs and 20% for EPs.
Meaningful Use Audits (cont'd)

March, 2013: CMS Issues FAQ #7711

- Re-asserts that any single shortfall results in recoupment.

- “To ensure you are prepared for a potential audit, save the electronic or paper documentation that supports your attestation.”

- “An audit may include a review of any of the documentation needed 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 include an all-inclusive list of supporting documents.”
Meaningful Use Audits (cont'd)

The same CMS guidance also stated:

- The accounting firm Figliozzi & Company will be the designated contractor performing audits on behalf of CMS, and will perform 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.

- The individual states and their contractors will perform audits on Medicaid providers.
Overview of the CMS EHR Incentive Programs Audits

- All providers attesting to receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Programs should retain ALL relevant supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses. Documentation to support the attestation should be retained for six (6) years post-attestation. Documentation to support payment calculations (such as cost report data) should continue to follow the current documentation retention processes.

- CMS, and its contractors, will perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers.

- States, and their contractors, will perform audits on Medicaid providers.

- CMS and states will also manage appeals processes.
Overview of the CMS EHR Incentive Programs Audits (cont'd)

- Preparing for an Audit
  - To ensure you are prepared for a potential audit, save the 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 (CQMs). Hospitals should also maintain documentation that supports their payment calculations.
  
  - Upon audit, the documentation will be used to validate that the provider accurately attested and submitted CQMs, as well as to verify that the incentive payment was accurate.
Details of the Audits

- There are numerous pre-payment edit checks built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment.

- Post-payment audits will also be completed during the course of the EHR Incentive Programs.

- If, based on an audit, a provider is found to not be eligible for an EHR incentive payment, the payment will be recouped.

- CMS has an appeals process for eligible professionals, eligible hospitals, and critical access hospitals that participate in the Medicare EHR Incentive Program.

- States will implement appeals processes for the Medicaid EHR Incentive Program. For more information about these appeals, please contact your State Medicaid Agency.
When Selected for Audit

- For Medicare eligible professionals and for hospitals that are eligible for both Medicare and Medicaid EHR incentive payments - When a provider is selected for an audit, they will receive an initial request letter from the audit contractor. The request letter will be sent electronically by the audit contractor from a CMS email address and will include the audit contractor’s contact information. The email address provided during registration for the EHR Incentive Program will be used for the initial request letter.

- The initial review process will be conducted at the audit contractor’s location, using the information received as a result of the initial request letter. Additional information might be needed during or after this initial review process, and in some cases an on-site review at the provider’s location could follow. A demonstration of the EHR system could be requested during the on-site review. A secure communication process has been established by the contractor, which will assist the provider to send any information that could be considered sensitive. Any questions pertaining to the information request should be directed to the audit contractor.

- States will have separate audit processes for their Medicaid EHR Incentive Program. For more information about these audit processes, please contact your State Medicaid Agency.
Documentation

- 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 include an all-inclusive list of supporting documents.

- 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.
Summary Documentation

- This summary 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 eligible professional, eligible hospital, or critical access hospital.

- 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.
Document Retention For Audit

- What information should an eligible professional, eligible hospital, or critical access hospital participating in the Medicare or Medicaid Electronic Health Record (EHR) Incentive Programs maintain in case of an audit?
Meaningful Use Audits - Guidance

CMS guidance, issued in February of 2013 states the following in regards to supporting documentation for audits:

- Providers who receive an EHR incentive payment for either the Medicare or Medicaid 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 (6) years post-attestation.
A Few Examples of Additional Support are as Follows:

- Drug-Drug/Drug-Allergy Interaction Checks and Clinical Decision Support – Proof that the functionality is available, enabled, and active in the system for the duration of the EHR reporting period.
- Electronic Exchange of Clinical Information – Screenshots from the EHR system or other documentation that document a test exchange of key clinical information (successful or unsuccessful) with another provider of care. Alternately, a letter or email from the receiving provider confirming the exchange, including specific information such as the date of the exchange, name of providers, and whether the test was successful.
- Protect Electronic Health Information – Proof that a security risk analysis of the certified EHR technology was performed prior to the end of the reporting period (e.g., report which documents the procedures performed during the analysis and the results).
- Drug Formulary Checks – Proof that the functionality is available, enabled, and active in the system for the duration of the EHR reporting period.
- Immunization Registries Data Submission, Reportable Lab Results to Public Health Agencies, and Syndromic Surveillance Data Submission – Screenshots from the EHR system or other documentation that document a test submission to the registry or public health agency (successful or unsuccessful). Alternately, a 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.
Red Flags

- **Elements of provider attestation**
  - *Inconsistency between numerator / denominators that should be related*
  - *Exclusions that may be inconsistent with other measures*

- **CMS Data supplemental to attestations**
  - *Measures or exclusions inconsistent with patient mix (both hospital and EP specialty)*
  - *Peer group comparisons*
  - *State and local public health capabilities*

- **EHR Vendor characteristics**
  - *Providers who indicated use of multiple EHR products to meet requirements*
  - *EHR’s with capability of collecting data for only a few CQM’s (ambulatory only)*
  - *Representative sample of Certified EHR vendors*
What Happens if I Fail an Audit?

- Appeal?
  - What caused the fail?
    - E.g., audit logs – EHR certification process did not require this for specific functionality
      - Core Objective 2: Drug-drug and drug-allergy interaction checks
      - Core Objective 11: Clinical decision support rule
      - Menu Objective 1: Drug formulary checks
  - or… Do nothing
    - Learn from mistakes, return the incentive money and move forward!

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Review, Withdrawal and Appeal

- To date the review standard is Pass/Fail.
- Documentation for attestation and core measures are reviewed.
- All measures must be accomplished and documented to pass.
- A properly performed and documented risk assessment must be presented to the auditor.
- You can withdraw and pay the funds back prior to being audited if you believe this is a proper business decision.
- You cannot pay them back during an audit.
- You can appeal the audit but you must have sufficient documentation to support your appeal.
Client Experiences: Best Practices

- Designate a person to be in charge in the event of an audit, and to own the “Book of Evidence.”
- Keep internal teams informed, and aware of procedures.
- Establish contact with auditor.
- Monitor the deadlines established by the auditor.
- Seek the EHR vendor for support.
- Seek counsel if needed!
Client Experiences: Lessons Learned

The most common points of interest for audits include:

- Core Measure #15 – Security Risk Analysis
  - Have to have this and has to cover specific areas
    - Refer to the OCR Guidance on Risk Analysis

- Method used to incorporate Emergency Department (ED) patients (All ED Visits or Observation Services)

- Yes/No measures

- “Proof of Possession”
Client Experiences: Lessons Learned (cont'd)

Recommended “Book of Evidence” includes, but is not limited to:

- EHR vendor purchase agreements;
- EHR implementation documents (project plans, configuration documents, etc.);
- Attestation reports generated from the EHR which reconciles exactly to the attestations made for each Core and Quality measure;
- Documentation for Public Health measures with confirmation emails from contacts at the Public Health Agencies (where applicable);
- A statement about change control and source code control systems which documents that functionality such as Drug/Allergy Interaction Checking, Drug Formularies and Clinical Decision Support Rules were enabled for the entire reporting period;
- Documentation that explains the interpretations made by management for measures where exclusions were taken;
- Complete Security Risk Analysis documentation – including identified threats and mitigation plans (as per OCR guidance); and
- Screenshots, screenshots, screenshots.
Confusing Advice
Important Payment Adjustment Information For Medicare EPs

Eligible professionals (EPs) participating in the Medicare EHR Incentive Program may be subject to payment adjustments beginning on January 1, 2015.

CMS will determine the payment adjustment based on meaningful use data submitted prior to the 2015 calendar year. EPs must demonstrate meaningful use prior to 2015 to avoid payment adjustments.

Determine how your EHR Incentive Program participation start year will affect the 2015 payment adjustments:

If you began in 2011 or 2012…
If you first demonstrated meaningful use in 2011 or 2012, you must demonstrate meaningful use for a full year in 2013 to avoid the payment adjustment in 2015.

If you began in 2013…
If you first demonstrate meaningful use in 2013, you must demonstrate meaningful use for a 90-day reporting period in 2013 to avoid the payment adjustment in 2015.
Important Payment Adjustment Information For Medicare EPs – (Cont'd)

If you plan to begin in 2014...

If you first demonstrate meaningful use in 2014, you must demonstrate meaningful use for a 90-day reporting period in 2014 to avoid the payment adjustment in 2015. This reporting period must occur in the first nine (9) months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, to avoid the payment adjustment.

Avoiding Payment Adjustments in the Future

You must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you MUST demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.
Reminder: Important Payment Adjustment Information for Medicare EPs: 12-17-13

- Eligible professionals (EPs) participating in the Medicare EHR Incentive Program may be subject to payment adjustments beginning on **January 1, 2015**. CMS will determine the payment adjustment based on meaningful use data submitted prior to the 2015 calendar year. EPs must demonstrate meaningful use prior to 2015 to avoid payment adjustments.

- Determine how your EHR Incentive Program participation start year will affect the 2015 payment adjustments.

  **If you began in 2011 or 2012…**
  If you first demonstrated meaningful use in 2011 or 2012, you must **demonstrate meaningful use for a full year in 2013 to avoid the payment adjustment in 2015**.

  **If you began in 2013…**
  If you first demonstrate meaningful use in 2013, you must demonstrate meaningful use for a **90-day reporting period in 2013 to avoid the payment adjustment in 2015**.

  **If you plan to begin in 2014…**
  If you first demonstrate meaningful use in 2014, you must demonstrate meaningful use for a **90-day reporting period in 2014 to avoid the payment adjustment in 2015**. This reporting period must occur in the first nine (9) months of calendar year 2014, and EPs must attest to meaningful use no later than October 1, 2014, to avoid the payment adjustment.

- **Avoiding Payment Adjustments in the Future**
  You must continue to demonstrate meaningful use every year to avoid payment adjustments in subsequent years.

  If you are eligible to participate in both the Medicare and Medicaid EHR Incentive Programs, you **MUST** demonstrate meaningful use to avoid the payment adjustments. You may demonstrate meaningful use under either Medicare or Medicaid.

  If you are only eligible to participate in the Medicaid EHR Incentive Program, you are not subject to these payment adjustments.
CMS and ONC announced the intent to change the Stage 3 timeline and extend Stage 2 of meaningful use through 2016.

Important to note about the proposed timeline:
It does not delay the start of Stage 2 of meaningful use.
It does not affect the current reporting periods and deadlines for 2014 participation.

What this Means for You:
• If you begin participation with your first year of Stage 1 for the Medicare EHR Incentive Program in 2014:
  You must begin your ninety (90) days of Stage 1 of meaningful use no later than July 1, 2014, and submit attestation by October 1, 2014, in order to avoid the 2015 payment adjustment.

• If you have completed 1 year of Stage 1 of meaningful use:
  You will demonstrate a second year of Stage 1 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare or any ninety (90) days for Medicaid.
  You will demonstrate Stage 2 of meaningful use for two years (2015 and 2016).
  You will begin Stage 3 of meaningful use in 2017.

• If you have completed two or more years of Stage 1 of meaningful use:
  You will still demonstrate Stage 2 of meaningful use in 2014 for a three-month reporting period fixed to the quarter for Medicare or any ninety (90) days for Medicaid.
  You will demonstrate Stage 2 of meaningful use for three years (2014, 2015 and 2016).
  You will begin Stage 3 of meaningful use in 2017.

Please be sure to look for additional guidance in the Federal Register for rulemaking on this proposal.
BEGINNING IN 2015, MEDICARE ELIGIBLE PROFESSIONALS WHO DO NOT SUCCESSFULLY DEMONSTRATE MEANINGFUL USE WILL BE SUBJECT TO A PAYMENT ADJUSTMENT. THE PAYMENT REDUCTION STARTS AT 1% AND INCREASES EACH YEAR THAT A MEDICARE ELIGIBLE PROFESSIONAL DOES NOT DEMONSTRATE MEANINGFUL USE, TO A MAXIMUM OF 5%.
Former CFO indicted over fraudulent meaningful use claims - February 11, 2014

- White faces up to seven (7) years in prison. CFO of now-closed Shelby Regional Medical Center in Texas, has been indicted for allegedly defrauding the federal government of nearly $800,000. Shelby was among thousands of providers that received payments through the government's meaningful use program. Under the program, health care providers who demonstrate meaningful use of certified electronic health record (EHR) systems can qualify for Medicaid and Medicare incentive payments.

- The indictment states that Shelby was granted $785,655 in January 2013 for successful demonstration of meaningful use during the 2012 full-year reporting period. In addition, the hospital had received $1.17 million in meaningful use payments from CMS in November 2011.

- The indictment alleges that he:
  - Submitted the attestation while knowing the hospital did not meet the program's requirements and "only minimally used the EHR platform and continued to use paper records and charts as well as older, uncertified technology";
  - Directed the hospital's EHR vendor to input data into the system manually from paper records and other sources, even after the FY 2012 reporting period; and
  - "[K]nowingly and willingly made materially false, fictitious and fraudulent statements and representations, and made and used false writings and documents" to defraud the EHR incentive program.
Questions?
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Partner
Austin, Texas
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Brian.Flood@huschblackwell.com
Thank You
Post-Pay Audit Engagement Letter & Information Request

RE: HITECH EHR Meaningful Use
Post-Pay Audit Engagement Letter & Information Request
Program Year 2011
Payment Year 1

Dear [Name],

The Centers for Medicare and Medicaid Services (CMS) has contracted with Figliozzi & Company, CPAs P.C.\(^1\) to conduct meaningful use audits of certified Electronic Health Record (EHR) technology as required in Section 13411 of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as included in Title XIII, Division A, Health Information Technology and in Title IV of Division B, Medicare and Medicaid Health Information Technology of the American Recovery and Reinvestment Act of 2009. The HITECH Act provides the Secretary, or any person or organization designated by the Secretary, the right to audit and inspect any books and records of any person or organization receiving an incentive payment.

This letter is to inform you that you have been selected by CMS for an audit of your meaningful use of certified EHR technology for the attestation period. Attached to this letter is an information request list. Be aware that this list may not be all-inclusive and that we may request additional information necessary to complete the audit.

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\(^{1}\) Please feel free to contact the EHR Information Center at 1-888-734-6433 or log onto the CMS EHR Website at http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRincentivePrograms/Attestation.html#10.
Please supply all requested items by , 2013 utilizing one of the following methods:

1. Electronically uploading the information to our secure web portal (see step by step instructions attached)

2. Mailing the information to:
   Figliozzi & Company, CPAs P.C.
   585 Stewart Avenue
   Suite 416
   Garden City, NY 11530

The contracts between CMS and its contractors contain a confidentiality of information clause that state propriety information or data submitted by or pertaining to an organization cannot be released without the prior written consent of the organization. Additionally, the contractors are required to obtain written permission from CMS’s contract officer whenever the contractor is uncertain on the proper handling of material under the contract. Further, if any information contained within the records your organization submits to CMS’s contractors constitutes confidential information, as such terms are interpreted under the Freedom of Information Act (FOIA) (5 U.S.C. § 552) and applicable case law, CMS will protect such information from release when requested under FOIA in accordance with the Department of Health and Human Services regulations (45 C.F.R. § 5.65 (c)).

If you have any questions, please contact your assigned auditor, which can be found in the body of the email.

Sincerely,

Peter Figliozzi CPA, CFF, FCPA
First and Final Request for Repayment

, 2013

RE: HITECH Incentive Payment
Provider Name: 
Provider NPI: 
Outstanding Balance: 
HITECH Transaction Number: 

Dear Sir/Madam,

The purpose of this letter is to inform you that a Meaningful Use Audit determined a HITECH incentive overpayment in the amount of $ for / to be repaid to our office in full. The registrant is responsible for the registration and attestation surrounding the eligibility to participate in the HITECH Incentive program and has independently received a full audit notification of the denial. As a result of the meaningful use audit, an overpayment of HITECH funds has been determined and is owed.

Please return the overpaid amount to us by /2013 and no interest charge will be assessed. Make the check payable to EHR HITECH Incentive Payment and send it with a copy of this letter to:

EHR HITECH Incentive Payment Center
P.O. Box 808338
Chicago, IL 60680-8338

If you do not refund in full within 30 days: In accordance with 42 CFR 405.378 simple interest at the rate of \% will be charged on the unpaid balance of the overpayment beginning on the 31st day.

If your debt reaches 61 days delinquent your debt will be referred to the Department of Treasury’s Debt Collection Center (DCC) for Cross Servicing and Offset of Federal Payments. Your debt will be referred under provisions of federal law, title 31 of the United States Code, Section 3720A and the authority of the Debt Collection Improvement Act of 1996.

The Debt Collection Center will use various tools to collect the debt, including offset, demand letters, phone calls, referral to a private collection agency and referral to the Department of Justice for litigation. Other collection tools available, which may be used, include Federal salary offset and administrative wage garnishment. If the debt is discharged, it may be reported to the IRS as potential taxable income. During the collection process, interest will continue to accrue on the debt and you will remain legally responsible for any amount not satisfied through the collection efforts.
For individual Debtors Filing a Joint Federal Income Tax Return

The Treasury Offset Program automatically refers debts to the IRS for offset. Your Federal income tax refund is subject to offset under this program. If you file a joint income tax return, you should contact the IRS before filing your tax return to determine the steps to be taken to protect the share of the refund which may be payable to the non-debtor spouse.

Federal Salary Offset

If the facility ownership is either a sole proprietorship or partnership, your individual salary(s) may be offset if you are or become a federal employee.

Due Process

You have the right to request an opportunity to inspect and copy records relating to the debt. This request must be submitted in writing to the address listed below. You have a right to present evidence that all or part of your debt is not past due or legally enforceable. In order to exercise this right, this office must receive a copy of the evidence to support your position, along with a copy of this letter. You must submit any evidence that the debt is not owed or legally enforceable within 60 days of the date of this letter. If, after sixty days from the date of this letter, we have not received such evidence, your debt, if it is still outstanding and eligible for referral, will be referred to the Department of Treasury or its designated Debt Collection Center for cross servicing/offset.

Please contact the EHR HITECH Incentive Payment Center immediately at 1-855-223-1343 if:

- You are unable to make full payment at this time and are requesting approval for an extended repayment plan. To determine eligibility for a repayment plan, (Refer to Financial Management Manual 100-06, Chapter 4, Section 50.2; Subsection 401.607(c) of Title 42 CFR for details.)

- You have filed a bankruptcy petition or are involved in a bankruptcy proceeding. Medicare financial obligations will be resolved in accordance with the applicable bankruptcy process. If possible, when notifying us about the bankruptcy please include the name the bankruptcy is filed under and the district where the bankruptcy is filed.

Contact the Electronic Health Record (EHR) Information Center if you disagree with this overpayment decision and wish to file an appeal via email or a toll-free hotline:

- Email -- Providers can submit an appeal request by visiting https://questions.cms.gov/newrequest.php

- Toll-free hotline -- Providers may also contact call the toll free number, 888-734-6433, between 9 a.m. and 5 p.m. EST, Monday through Friday.

Additional appeal information may be found on the EHR Incentive Programs website.


Sincerely,

EHR HITECH Incentive Payment Center
Hospital Appeal Filing Request

Instructions:

This request allows a provider to formally appeal an issue within the EHR Incentive Program. No review of any issue will begin until this form is completed and submitted along with any and all required attachments to the Electronic Health Record (EHR) Information Center https://questions.cms.gov/newrequest.php. Providers may also contact call the toll free number, 888-734-6433, between 9 a.m. and 5 p.m. EST, Monday through Friday.

Section 1: Appeal Request Information

1.1 What facility type best describes your EHR Incentive Program enrollment:

- Hospital qualified for or participating in the Medicare EHR Incentive Program
- Critical Access Hospital qualified for or participating in the Medicare EHR Incentive Program
- Medicare Advantage Organization representing a MA-Affiliated hospital qualified for or participating in the Medicare EHR Incentive Program
- Hospital qualified to participate in both Medicare and Medicaid EHR Incentive Programs
- Hospital participating in the Medicaid EHR Incentive Program
- Other (Please specify)

1.2 Please indicate which appeal you would like to file. (Check all that apply)

- An **eligibility appeal** allows a hospital to show that all the EHR Incentive Program requirements were met and the hospital should have received a payment but could not because of circumstances outside of the hospital’s control.

- A **meaningful use appeal** allows a hospital to show that the hospital used certified electronic health record technology and that the hospital is a meaningful user.

- Other (Please explain)

Section 2: Hospital Information

2.1 Please provide the following information regarding the hospital that is applying for the EHR Incentive Program.
a. Hospital name

b. CMS Certification Number (CCN) used to register for the EHR Incentive Program

c. Business address

d. Business telephone number

e. National Provider Identifier (NPI) associated with the EHR Incentive Program

f. Certified EHR Technology Product name used by the hospital

g. CMS EHR Certification ID, which was provided by the Office of the National Coordinator (ONC)

2.2 Please provide the information below for the person working on behalf of the hospital for the EHR Incentive Program.

a. Name

b. Title

c. Telephone number

d. Email address

e. Correspondence address
   Check if same as business address
Section 3: EHR Incentive Program Information

3.1 Did you successfully register in the EHR Incentive Program? Yes No

3.2 Did you successfully attest in the EHR Incentive Program? Yes No

3.3 Have you contacted the EHR Information Center regarding any issues related to this appeal request? Yes No

   If yes, please provide all relevant Inquiry ID numbers provided to you by the EHR Information Center:

3.4 Please fill in your EHR Reporting Period.

   EHR Reporting Period start date (MM/DD/YYYY):

   EHR Reporting Period end date (MM/DD/YYYY):

3.5 Did your EHR technology output incorrect data? Yes No

3.6 Can you show meaningful use by electing a new 90-day reporting period? Yes No
   If yes: Please indicate the new 90-day Reporting period:

   EHR Reporting Period start date (MM/DD/YYYY):

   EHR Reporting Period end date (MM/DD/YYYY):

3.7 Did you receive an EHR incentive payment? Yes No
Section 4: Appeal Issues

4.1 Please check the issues regarding your qualification or participation in the EHR Incentive Program that correspond to the appeal type checked below.

Please note: All issues must be raised for each applicable appeal type during this initial appeal filing.

Appeal Type:

Eligibility
   Unable to register due to a PECOS error
   Unable to register out of provider's control

Meaningful Use
   Non-certified EHR technology
   Adverse audit

Other
   Canceled previous year's attestation and request to attest for current year
   Withdrew attestation – returned payment
Hospital Appeal Filing Request (Cont'd)

Section 5: File appeal

Disclaimer: I hereby accept and attest that the information provided above is true, accurate, and complete to the best of my knowledge and that all relevant appeal issues for each appeal type have been raised for review by CMS. I understand that any falsification, omission, or concealment of any material fact may subject me to administrative, civil, or criminal liability.

Accept       Decline

5-01/03/13
Section 6: Supporting documentation

Supporting documentation checklist:

- Certified EHR Technology proof of purchase
- Reports from the facility’s certified EHR Technology that validate the 14 core measures and/or exclusions
- Reports from the facility’s EHR Technology that validate the five menu measures
- Reports from the facility’s EHR Technology that validate the 15 CQMs

Additional documentation: Please provide an explanation for the additional documentation included in the space below (attach additional pages, if necessary):
HITECH EHR Meaningful Use Audit Determination Letter

RE: HITECH EHR Meaningful Use Audit Determination Letter

CCN
NPI
Attestation Period
Program Year
Payment Year

Dear [Facility Name],

We have completed our meaningful use audit of the Certified Electronic Health Record (EHR) Technology of [Facility Name], in accordance with Section 13411 of the Health Information Technology for Economic and Clinical Health Act (HITECH Act), as included in Title XIII, Division A, Health Information Technology and in Title IV of Division B, Medicare and Medicaid Health Information Technology of the American Recovery and Reinvestment Act of 2009. The HITECH Act provides the Secretary, or any person or organization designated by the Secretary, the right to audit and inspect any books and records of any organization receiving an incentive payment.

We performed a desk review on your facility’s meaningful use attestation for the Program Year 20[Program Year] and Payment Year[Payment Year]. Based on our desk review of the supporting documentation furnished by the facility, we have determined that [Facility Name] has not met the meaningful use criteria, for the following reasons:

[Include specific reasons here]
- Failed to demonstrate access to a CEHRT system
- Failed Eligible Hospital Meaningful Use Core Measure 3 – Maintain Problem List
- Failed Eligible Hospital Meaningful Use Core Measure 4 – Active Medication List
- Failed Eligible Hospital Meaningful Use Core Measure 14 – Protect Electronic Health Information

Since your facility did not meet the meaningful use criteria, the incentive payment will be recouped. You will receive a demand for your total Medicare EHR incentive payment shortly from the EHR HITECH Incentive Payment Center. The demand letter will include all information regarding the repayment process, and will also include your appeal rights.

This audit does not preclude future audits in this payment year or in subsequent years.

Sincerely,

Peter Figliozzi, CPA, CFF, FCPA