HealthCare
Kentucky Regional Extension Center

BI-MONTHLY TIP ON MEANINGFUL USE

Documentation to Retain

Why is it important to Retain Information?

Documentation for an attestation needs to be stored in an organized method for up to 6 years after the attestation has been submitted. Upon the request for an audit, providers have a short amount of time to provide all of the supporting documents to be reviewed. If you are unable to provide the supporting documentation to pass the audit, the incentive money may be recouped.

What documents do you recommend I store?

Attached to this email is the recommended documentation to be retained list for 2017 Eligible Providers Modified Stage 2 measures. Please take time to review during the reporting period and obtain the necessary screenshots for each measure. Also make sure to save all Meaningful Use and Clinical Quality Measure Reports that are used for the attestation submission.

How do you obtain a screen shot?

There are several ways to obtain a screen shot. The most common method is to push the Control + Print Screen keys on your keyboard. Then open a Word document and right click and click paste. The screen that you are capturing should paste itself in the Word Document. Save and Print a hardcopy for your binder.

There is also a snapshot feature on many programs, along with add-ins for completing this task.

Best Practices:

Store your supporting documentation both as a hardcopy and electronic format.

- Create folders that are per provider and per program year. This makes it easier to find if audited for a particular provider/year.
- Create an audit procedure. This is very helpful in the case of employee turnover. The policy would state where documents are stored and explanations to any exclusions/issues that happed during that year. If a new employee is being asked for documentation from previous years of employment, they will be able to locate what is needed.
- Keep everything together, including the Security Risk Assessment.
- When adding documents to the binder, create tabs labeling what MU year the information is being saved for, if multiple years are stored in one binder.

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Common Errors:

- Documentation was not stored in an organized method and could not be found at a later date.
- Reports do not include the providers name and/or dates.
- Several sets of reports are stored in a binder and practice does not know which reports were used for the attestation.
- Screen shots were not obtained to prove features were turned on during the reporting period.
- Screen shots of features do not show dates.
- Supporting documentation included patient information and was not stored according to HIPAA rules.
- The Security Risk Assessment binder cannot be found with the MU folders at time of the audit.

You may also contact your Kentucky REC Health IT Advisor for information.

EHR Incentive Programs in 2015-2017 Supporting Documentation for Audits:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/AppealsAudits_2015through2017SupportDoc.pdf

EHR Incentive Programs Audits Overview:

https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/AppealsAudits_EHRAuditsOverview-.pdf

Eligible Professionals- 2017 Modified Stage 2 Objective Measures

Measure	Suggested Documentation	Suggested Documentation For Exclusions
EPOM 01 Protect Patient Health Information	A security risk analysis of the EP's Certified Electronic Health Record Technology (CEHRT) system, which was performed no earlier than the start of the reporting year and no later than the date of attestation (i.e. a report which documents the procedures performed during the analysis and the results of the analysis). This analysis must be in accordance with the requirements under 45 CFR 164.308(a) (1), **including** addressing the encryption/security of data stored in CEHRT in accordance with requirements under 45 CFR 164.312 (a)(2)(iv) and 45 CFR 164.306(d)(3). The testing could occur prior to the beginning of the first EHR reporting period. However, a new review would have to occur for each subsequent reporting period. Documentation should also be supplied to show that the EP implemented security updates as necessary and corrected identified security deficiencies.	There is no exclusion for this measure.
EPOM 02 Clinical Decision Support	**For Measure #1-** Documentation which proves that five clinical decision support interventions exist in the EP's CEHRT system (i.e. audit trail, screenshots from the system, letter/e-mail from the vendor, etc.) and that they remained active throughout the EP's reporting period (i.e. a schedule of alerts related to clinical decision support interventions that fired during the reporting period or an indication that the interventions can not be turned off). ***For Alternate Measure #1*** - Documentation which proves that a clinical decision support rule exists in the EP's CEHRT system (i.e. audit trail, screenshots from the system, letter/e-mail from the vendor, etc.) and that it remained active throughout the EP's reporting period (i.e. a schedule of alerts related to a clinical decision support rule that fired during the reporting period or an indication that the rule can not be turned off). **For Measure #2-** Documentation which proves that this functionality is available in the EP's EHR system (i.e. audit trail, screenshots from the system, letter/e-mail from the vendor, etc.) and that it remained active throughout the EP's reporting period (i.e. a schedule of alerts that fired during the reporting period or an indication that the feature can not be turned off).	**There is no exclusion for the first measure.** To meet the exclusion for the second measure, the EP is required to write fewer than 100 medication orders during the EHR reporting period. To support this exclusion, provide the following: A summary report, preferably generated by the EP's Certified Electronic Health Record Technology system. This report should include the following: • Denominator for Objective Measure #3 (Medication) which should be < 100 • Time period which it covers • Name of the EP
EPOM 03 CPOE for Medication, Laboratory, andRadiology Orders	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology (CEHRT) system. This report should include the following: • Numerators and denominators for all three CPOEs • Time period which it covers (must cover the attestation period) • Name of the EP If possible, evidence demonstrating that this report was generated by the CEHRT system (i.e. a screenshot of the report before it has been printed from the system).	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology system. This report should include the following: • Denominators for this measure, which should be < 100 (should be 3 sets of numerators & denominators: Medication, Laboratory, Radiology) • Time period which it covers (must cover the attestation period) • Name of the EP Note- These exclusions are independent of each other. For example, an EP can be excluded from the medication order measure, but be required to report the laboratory and radiology order measures, based on the threshold of writing 100 orders.

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EPOM 04 Electronic Prescribing (eRx)	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology (CEHRT) system. This report should include the following: • Numerator and denominator for this measure • Time period which it covers (must cover the attestation period) • Name of the EP If possible, evidence demonstrating that this report was generated by the CEHRT system (i.e. a screenshot of the report before it has been printed from the system).	One of the following exclusions must be documented: **Exclusion #1A**- A summary report, preferably generated by the EP's CEHRT system. This report should include the following: • Denominator, which must be < 100 • Time period which it covers (must cover the attestation period) • Name of the EP **Exclusion #1B**- A statement indicating that at the start of the EHR reporting period, the EP did not have a pharmacy within their organization or within 10 miles of their practice that accepted electronic prescriptions.
EPOM 05 Health Information Exchange	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology (CEHRT) system. This report should include the following: • Numerator and denominator for this measure • Time period which it covers (must cover the attestation period) • Name of the EP If possible, evidence demonstrating that this report was generated by the CEHRT system (i.e. a screenshot of the report before it has been printed from the system).	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology system. This report should include the following: • Denominator for this measure which should be < 100 • Time period which it covers • Name of the EP
EPOM 06 Patient-Specific Education	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology (CEHRT) system. This report should include the following: • Numerator and denominator for this measure • Time period which it covers (must cover the attestation period) • Name of the EP If possible, evidence demonstrating that this report was generated by the CEHRT system (i.e. a screenshot of the report before it has been printed from the system).	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology system. This report should include the following: • Denominator for this measure which should be zero • Time period which it covers (must cover the attestation period) • Name of the EP
EPOM 07 Medication Reconciliation	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology (CEHRT) system. This report should include the following: • Numerator and denominator for this measure • Time period which it covers (must cover the attestation period) • Name of the EP If possible, evidence demonstrating that this report was generated by the CEHRT system (i.e. a screenshot of the report before it has been printed from the system).	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology system. This report should include the following: • Denominator for this measure which should be zero • Time period which it covers (must cover the attestation period) • Name of the EP

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EPOM 08 Patient Electronic Access	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology (CEHRT) system. This report should include the following: • Numerator and denominator for this measure (for both measure #1 & 2) • Time period which it covers (must cover the attestation period) • Name of the EP If possible, evidence demonstrating that this report was generated by the CEHRT system (i.e. a screenshot of the report before it has been printed from the system).	**Exclusion #1A**- A statement indicating why the EP does not order or create any of the information listed for inclusion as part of the measure (patient name, provider's name and office contact information, current and past problem list, procedures, laboratory test results, current medication list and medication history, current medication allergy list and medication allergy history, vital signs, smoking status, demographic information, care plan fields, and any known care team members including the primary care provider (PCP) of record) except for "Patient name" and "Provider's name and office contact information". **Exclusion #1B-** A statement identifying the county and zip code where the EP conducts ≥ 50% of his/her patient encounters. **(Excludes second measure only)**
EPOM 09 Secure Electronic Messaging	A summary report, preferably generated by the EP's Certified Electronic Health Record Technology (CEHRT) system. This report should include the following: • Numerator and denominator for this measure (for both measure #1 & 2) • Time period which it covers (must cover the attestation period) • Name of the EP If possible, evidence demonstrating that this report was generated by the CEHRT system (i.e. a screenshot of the report before it has been printed from the system).	One of the following exclusions must be documented: **Exclusion #1A-** A summary report, generated by the EP's Certified Electronic Health Record Technology system. This report should include the following: • Denominator for Measure #6 (Patient-Specific Education) which should be zero • Time period which it covers (must cover the attestation period) • Name of the EP **Exclusion #1B-** A statement identifying the county and zip code where the EP conducts ≥ 50% of his/her patient encounters.

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EPOM 10 PublicHealth Reporting	One of the following criteria must be documented for each attested to measure: **For Active Engagement Option (1)**, documentation from the EP's public health agency (letter, e-mail, website screenshot, etc.) demonstrating the EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted; registration was completed within 60 days after the start of the EHR reporting period; and the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. An example of acceptable documentation would be a letter or e-mail from the public health agency confirming the date the EP registered to submit data with the PHA or, where applicable, the CDR to which the information is being submitted and that the EP is awaiting an invitation from the PHA or CDR to begin testing and validation. **For Active Engagement Option (2)**, documentation from the EP's public health agency (letter, e-mail, website screenshot, etc.) demonstrating that the EP is in the process of testing and validation of the electronic submission of data. Providers must respond to requests from the PHA or, where applicable, the CDR within 30 days; failure to respond twice within an EHR reporting period would result in that provider not meeting the measure. An example of acceptable documentation would be a letter or e-mail from the public health agency confirming that the EP is in the process of testing and validation of the electronic submission of data. **For Active Engagement Option (3)**, documentation from the EP's public health agency (letter, e-mail, website screenshot, etc.) demonstrating that the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR. An example of acceptable documentation would be a letter or e-mail from the public health agency confirming that the EP has completed testing and validation of the electronic submission and is electronically submitting production data to the PHA or CDR.	One of the following exclusions must be documented: **Exclusion#1-** Measure #1 - A statement from the EP detailing what types of immunizations, if any, they administered during the reporting period. If the EP administers immunizations that are not being collected by the registry, obtain confirmation from the registry. Measure #2 - A statement from the EP indicating why they are not in a category of providers that collects ambulatory syndromic surveillance information. Measure #3 - A statement from the EP explaining why they do not diagnose or directly treat any disease associated with a specialized registry or the public health agencies in their jurisdiction. **Exclusion#2-** Measure #1 - Documentation from the EP's immunization registry or immunization information system (letter, e-mail, website screenshot, etc.) stating that they were not capable of accepting the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. Measure #2 - Documentation from the EP's public health agency (letter, e-mail, website screenshot, etc.) stating that they were not capable of receiving electronic syndromic surveillance data from EPs in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. Measure #3 - Documentation from the EP's specialized registry (letter, e-mail, website screenshot, etc.) stating that they were not capable of accepting electronic registry transactions in the specific standards required to meet the CEHRT definition at the start of the EHR reporting period. **Exclusion#3-** Measure #1 - Documentation from the EP's immunization registry or immunization information system (letter, e-mail, website screenshot, etc.) which demonstrates that EP operates in a jurisdiction where no immunization registry or immunization information system has declared readiness to receive immunization data from the EP at the start of the EHR reporting period. Measure #2 - Documentation from the EP's public health agency (letter, e-mail, website screenshot, etc.) which demonstrates that EP operates in a jurisdiction where no public health agency has declared readiness to receive syndromic surveillance data from EPs at the start of the EHR reporting period. Measure #3 - Documentation from the EP's specialized registry (letter, e-mail, website screenshot, etc.) which demonstrates that EP operates in a jurisdiction where no specialized registry for which the EP is eligible has declared readiness to receive electronic registry transactions at the beginning of the EHR reporting period.
Clinical Quality Measures	Medicaid EPs are required to report on any six measures that are relevant to the EP's scope of practice from a list of 53 available Clinical Quality Measures. A summary report, preferably generated by the EP's Certified Electronic Health Record Technology system. This report should include the following: • Denominator, Numerator, Exclusion, Exception • Reporting period dates • Name of provider	No Exclusions