HealthCare
Kentucky Regional Extension Center

KY REC Tip for the Kentucky Medicaid EHR Incentive Program (Promoting Interoperability)

Suggested 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?

Listed below is the suggested documentation to be retained list for 2021 Eligible Providers Stage 3 measures. Please take time to review during the reporting period and obtain the necessary screenshots for each measure. Also make sure to save all Promoting Interoperability (Meaningful Use) and Clinical Quality Measure reports that are used for the attestation submission.

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How do I obtain a screen shot?

There are several ways to obtain a screen shot. The most common method is to utilize the Print Screen key(s) on your keyboard. Then open a Word document and right-click and select 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.

Common Errors:

- Documentation was not stored in an organized method and could not be found at a later date.
- Reports do not include the provider 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 PI folders at time of the audit.

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 happened 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.
- If multiple years are stored in one binder, create tabs labeling what program year the information is being saved for.

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

EHR Incentive Programs Audits Overview: https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Appeals_Audits

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Eligible Professionals – 2021 Stage 3 Suggested Documentation to Retain	
Objective 1: Protect Patient Health Information	• Security Risk Assessments/Analyses • Policies, procedures and forms, such as authorization and release forms • Training materials, dates, times and attendees • Breach notifications and investigations
Objective 2: Electronic Prescribing	• EHR report including provider name, provider NPI, 90 day reporting period, numerator, denominator and percentage • Screenshot of drug formulary
Objective 3: Clinical Decision Support	• Screenshot capture and list of CDS rules and tied CQMs • Screenshot capture of drug-drug and drug-allergy interactions
Objective 4: Computerized Provider Order Entry	• EHR report including provider name, provider NPI, 90 day reporting period, numerator, denominator and percentage • Screenshot of drug formulary
Objective 5: Patient Electronic Access	• EHR report including provider name, provider NPI, 90 day reporting period, numerator, denominator and percentage • If log sheet was used: log sheet, policy and hard copy of instructions • Proof that API is enabled and instructions given to patients on how to use API functionality
Objective 6: Coordination of Care Through Patient Engagement	• EHR report including provider name, provider NPI, 90 day reporting period, numerator, denominator and percentage
Objective 7: Health Information Exchange	• EHR report including provider name, provider NPI, 90 day reporting period, numerator, denominator and percentage • EHR or 3rd party HISP reports • Summary of Care document
Objective 8: Public Health & Clinical Data Registry Reporting	• Option 1: Signed participation agreements and addendums • Option 2: KHIE/Registry Testing and Validation Confirmation • Option 3: KHIE/Registry Go-Live Approval Form • Proof of active engagement with Public Health Registry • Proof of active engagement to send data to a Clinical Data Registry • Registration receipt
eCQMs	• EHR report including provider name, provider NPI, 90 day reporting period, numerator, denominator and percentage • QRDA III file

*This is a suggested list of documents to retain and may not include all items that are requested at time of an audit.