EHR Incentive Programs Audits Overview

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Overview

An eligible professional (EP), eligible hospital, or critical access hospital (CAH) attesting to receive an incentive payment for either the Medicare or Medicaid Electronic Health Record (EHR) Incentive Program may be subject to an audit.

The Centers for Medicare & Medicaid Services (CMS), and its contractor, Figliozzi and Company, will perform audits on Medicare and dually-eligible (Medicare and Medicaid) providers who are participating in the EHR Incentive Programs. States, and their contractor, will perform audits on Medicaid providers participating in the Medicaid EHR Incentive Program.

CMS may identify the need to communicate directly with an EP, eligible hospital, or CAH related to registration, attestation, audits or appeals. This communication will be conducted via the contact information provided during registration for the EHR incentive Program. Ensure all addresses, phone numbers, email addresses and specialties are current in the Registration & Attestation System, National Plan and Provider Enumeration System (NPPES), and Provider Enrollment Chain and Ownership System (PECOS).

Pre- and Post-Payment Audits

There are numerous pre-payment edit checks built into the EHR Incentive Programs' systems to detect inaccuracies in eligibility, reporting, and payment. Medicare providers may also be subject to pre-payment audits. These pre-payment audits will include random audits, as well as audits that target suspicious or anomalous data. For those providers selected for pre-payment audits, CMS and its contractor, Figliozzi and Company, will request supporting documentation to validate submitted attestation data before releasing payment.

CMS and Figliozzi and Company will also continue to conduct post-payment audits during the course of the EHR Incentive Programs. Providers selected for post-payment audits will also be required to submit supporting documentation to validate their submitted attestation data.

Audit Process

EPs, eligible hospitals, and CAHs should retain all relevant supporting documentation—in either paper or electronic format—used to complete the Attestation Module as follows:

- Documentation to support attestation data for meaningful use objectives and clinical quality measures should be retained for six years post-attestation
- Documentation to support payment calculations (such as cost report data) should follow the current documentation retention processes

Medicaid providers can contact their State Medicaid Agency for more information about audits for Medicaid EHR Incentive Program payments.

Overview of the Audit Process:

Engagement Letter - Providers selected for an audit will receive an initial request letter from the auditor. The request letter is sent electronically from a CMS email address and will include the audit contractor's contact information. The email address provided during registration for the EHR Incentive Programs is used for the initial request letter.

- Sample Audit Letter for EPs
- Sample Audit Letter for Eligible Hospitals and CAHs

Information Request List – A list will be attached to the engagement letter outlining all required documentation from CEHRT. The auditor may request additional documentation necessary to complete the audit. The email address on file should be monitored to ensure timely compliance with any requests.

Documentation Submission – The engagement letter will outline methods of submission and a deadline for submitting the required documentation. Documentation can be submitted electronically via a secure web portal or mailing the information to the auditor.

Review Process – The initial review process will be conducted at the audit contractor's location, using the information received from the initial request letter. Additional information may be requested during or after this initial review process and the email address on file should continue to be monitored to ensure timely compliance with any requests. In some cases an onsite review at the provider's location could follow. A demonstration of the certified 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.

Audit Determination – Once the audit is concluded, the provider will receive an Audit Determination Letter from the audit contractor. This letter will inform the provider whether they were successful in meeting meaningful use of CEHRT. If the provider did not demonstrate meaningful use of CEHRT, the letter will outline the measures failed and the appeal process. If, based on the audit, a provider is found not to be eligible for an EHR incentive payment, the payment will be recouped (post-payment audits) or payment will not be made (pre-payment audits). Payment recoupment will be communicated via a separate Demand Letter and will include all information regarding the repayment process.

Audit Contractor Contact Information - Questions pertaining to audits should be directed to Peter Figliozzi at (516) 745-6400 x302, or by email at pfigliozzi@figliozzi.com. To learn more, visit the Figliozzi and Company's website.

Medicare Fraud and Abuse

CMS may also pursue additional measures against providers who attest fraudulently to receive an EHR incentive payment. It is a crime to defraud the Federal Government and its programs. Punishment may involve imprisonment, significant fines, or both. Criminal penalties for health care fraud reflect the serious harms associated with health care fraud and the need for aggressive and appropriate fraud prevention. In some states, providers and health care organizations may lose their licenses. Convictions also may result in exclusion from

Medicare participation for a specified length of time. Medicare fraud may also result in civil liability. To learn more, visit the Medicare Fraud & Abuse page on the CMS website.