Meaningful Use Audit Preparation Checklist

This checklist is intended to help eligible professionals (EPs) prepare for a CMS audit of Stage 1 Meaningful Use attestation. The checklist is not based on official guidance from CMS because none has been issued as of the publication of this document. However, during registration and attestation EPs must agree to the following: "I hereby agree to keep such records as are necessary to demonstrate that I met all Medicare/Medicaid EHR Incentive Program requirements and to furnish those records to the Medicaid State Agency, Department of Health and Human Services, or contractor acting on their behalf." *UTILIZATION OF THIS CHECKLIST DOES NOT GUARANTEE THAT THE EP WILL PASS A CMS AUDIT.*

Audit documents may be maintained electronically or in paper form. If obtaining print screenshots from the EHR remove or black out any protected health information (PHI.) To prevent risk of modification of audit documents, print to a version that is not modifiable such as PDF and/or paper. Per CMS, all EPs, EH's, and CAHs must keep documentation supporting their demonstration of meaningful use for 6 years (Medicare and Medicaid EHR Incentive Program Final Rule p. 44571). States may have more stringent document retention requirements.

Important notes:

- **Core:** If the EP practices in more than one site/location that has CEHRT, the numerators and denominators from the core measures used for attestation need to include the patient records from **both/all** CEHRTs and any patient records maintained in paper or noncertified EHR for the relevant measures. For further guidance on calculating numerators and denominators from multiple locations, refer to CMS FAQ 3609.

- **Menu:** EPs who do not have the same menu objectives implemented across each of their practice locations equipped with CEHRT may attest to the five menu objectives that represent the greatest number of their patient encounters. For measures that utilize a percentage threshold, they can limit the denominator to the location or locations that pursued that menu objective. (Medicare and Medicaid EHR Incentive Program – Stage 2 – Final Rule p. 53981)

- **CQMs:** If an EP has greater than 50% of their clinical activity at one site, the EP can include only CQM data from the site where they see > 50% of their patients. (CQM Q&A Question 50)

- All certified modules or EHRs that were available at a practice(s) at the start of the EHR reporting period, must be added to the cart on the ONC Certified Health IT Product List (CHPL) website to generate an accurate CMS EHR Certification ID for the EP. Include a screenshot of the CHPL webpage with the certification ID in the audit file.

- All percentage-based reports generated from the EHR must identify that the report was generated by the EHR (i.e. EHR logo is displayed on the report or step-by-step screenshots demonstrate how the report is generated by the EHR).

- All claimed exclusions must also have supporting documentation.

- This checklist applies to MU attestation under **Stage 1**, for EPs attesting for **2012**

Meaningful Use Audit Preparation Checklist

Provider Name:			
Provider NPI:		CMS EHR Certification ID:	
Reporting Period Start Date:		Reporting Period End Date:	

☐ Documentation is attached demonstrating that at least 50% of patient encounters during the EHR reporting period occurred at a practice(s)/location(s) equipped with certified EHR technology.

Core Measures

1. **CPOE for Medications:** ☐ Exclusion Claimed. Reason:

   ☐ Audit Documentation: Report used to obtain the numerator and denominator OR to document reason for exclusion
   - ☐ EP reported using *ALL* patient records
   - ☐ EP reported using only patient records maintained in the certified EHR

2. **Drug Interaction Check:**

   ☐ Audit Documentation: Screenshot from EHR of settings showing active drug-drug and drug-allergy checking, for the entire reporting period, if possible, or an interaction alert audit report.

3. **Maintain Problem List:**

   ☐ Audit Documentation: Report used to obtain numerator and denominator

4. **e-Prescribing (eRx):** ☐ Exclusion Claimed. Reason:

   ☐ Audit Documentation: Report used to obtain the numerator and denominator **OR** to document reason for exclusion
   - ☐ EP reported using *ALL* patient records
   - ☐ EP reported using only patient records maintained in the certified EHR

5. **Active Medication List:**

   ☐ Audit Documentation: Report used to obtain numerator and denominator

6. **Medication Allergy List:**

   ☐ Audit Documentation: Report used to obtain numerator and denominator

7. **Demographics:**

   ☐ Audit Documentation: Report used to obtain numerator and denominator

8. **Vital Signs:** ☐ Exclusion Claimed. Reason:

   ☐ Audit Documentation: Report used to obtain the numerator and denominator **OR** to document reason for exclusion
   - ☐ EP reported using *ALL* patient records
   - ☐ EP reported using only patient records maintained in the certified EHR

CalHIPSO is a federally-designated Regional Extension Center funded by the Office of the National Coordinator, Department of Health and Human Services, ' Award Numbers: 90RC0031/01 and 90RC0034/01

9. Smoking Status: ☐ Exclusion Claimed. Reason:

☐ Audit Documentation: Report used to obtain the numerator and denominator **OR** to document reason for exclusion

- ☐ EP reported using *ALL* patient records
- ☐ EP reported using only patient records maintained in the certified EHR

10. Clinical Quality Measure (CQMs):

☐ Attach list of core or alternate core CQMs submitted

☐ Attach list of three additional CQMs selected

☐ Audit Documentation: Report used to obtain the numerator and denominator for each CQM

11. Clinical Decision Support Rule:

☐ Audit Documentation: Screenshot of the EHR showing use of a clinical decision support rule along with any and all documentation that the CDS has been in place and uninterrupted for the entire reporting period. You may have to contact your vendor for this documentation.

12. Electronic Copy of Health Information: ☐ Exclusion Claimed. Reason:

☐ Audit Documentation: Report used to obtain the numerator and denominator **OR** to document reason for exclusion

- ☐ EP reported using *ALL* patient records
- ☐ EP reported using only patient records maintained in the certified EHR

13. Clinical Summaries: ☐ Exclusion Claimed. Reason:

☐ Audit Documentation: Report used to obtain the numerator and denominator **OR** to document reason for exclusion

- ☐ Copy of a clinical summary showing that all required components are included.
- ☐ EP reported using *ALL* patient records
- ☐ EP reported using only patient records maintained in the certified EHR

14. Electronic Exchange of Clinical Information:

☐ Audit Documentation: screenshot documenting test of sending electronic health information plus documentation that the test was or was not successful/received.

15. Protect Electronic Health Information:

☐ Audit Documentation: In the event of an audit, the EP must be able to provide a copy of the security risk analysis. Keeping a copy of the security risk analysis in the EP audit file can be security vulnerability for an organization. As a compromise, consider placing a letter in the EP audit file similar to the following template:

To reduce the risk of security vulnerability, ***"Practice name here"*** will maintain a single security risk analysis for each EHR reporting period that will be available on demand to an auditing body in the event of a CMS EHR Incentive Program audit.

The security risk analysis for ***20xx*** was completed on **MM/DD/YY**. Necessary security updates were implemented and deficiencies corrected. Mitigation plans are in place.

Security Official (sign and date) _____

Eligible Professional (sign and date) _____

Menu Measures

EP must select five menu measures: at least one must be a public health measure

Selected		Menu Measures
Yes	No	
☐	☐	**1: Implemented drug-formulary checks**: ☐ Exclusion Claimed. Reason: ☐ Audit Documentation: Screenshot of the EHR showing use of a drug-formulary along with any and all documentation that this functionality has been in place and uninterrupted for the entire reporting period. You may have to contact your vendor for this documentation.
☐	☐	**2: Clinical Lab Test Results**: ☐ Exclusion Claimed. Reason: ☐ Audit Documentation: Report used to obtain the numerator and denominator
☐	☐	**3: Patient List:** ☐ Audit Documentation: report of patients with a specific condition (remove all patient identifiers)
☐	☐	**4: Patient Reminders**: ☐ Exclusion Claimed. Reason: ☐ Audit Documentation: Report used to obtain the numerator and denominator ☐ EP reported using ALL patient records ☐ EP reported using only patient records maintained in the certified EHR
☐	☐	**5: Patient Electronic Access**: ☐ Exclusion Claimed. Reason: ☐ Audit Documentation: Report used to obtain the numerator and denominator ☐ EP reported using ALL patient records ☐ EP reported using only patient records maintained in the certified EHR
☐	☐	**6: Patient-specific Education Resources:** ☐ Audit Documentation: Report used to obtain the numerator and denominator
☐	☐	**7: Medication Reconciliation**: ☐ Exclusion Claimed. Reason: ☐ Audit Documentation: Report used to obtain the numerator and denominator ☐ EP reported using ALL patient records ☐ EP reported using only patient records maintained in the certified EHR
☐	☐	**8: Transition of Care Summary**: ☐ Exclusion Claimed. Reason: ☐ Audit Documentation: Report used to obtain the numerator and denominator ☐ EP reported using ALL patient records ☐ EP reported using only patient records maintained in the certified EHR
☐	☐	**9: Immunization Registry Data Submission**: ☐ Exclusion Claimed. Reason: ☐ Audit Documentation: Screenshot from EHR demonstrating test submission of electronic data to immunization registries or documentation that registry does not have capacity to receive the information electronically (e.g., letter or email directly from the immunization registry).
☐	☐	**10: Syndromic Surveillance Submission**: ☐ Exclusion Claimed. Reason: ☐ Audit Documentation: Screenshot from EHR demonstrating test of capacity to provide electronic data to a public health agency or documentation that the public health agencies to which an EP submits such information do not have the capacity to receive the information electronically (e.g., letter or email directly from the public health agency).