MYERS AND STAUFFER LC
CERTIFIED PUBLIC ACCOUNTANTS

Audit Preparedness

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WHO ARE WE?

- CPA Firm that specializes in governmental clients

"Myers and Stauffer provides professional accounting, consulting, data management and analysis services to state and federal agencies managing government-sponsored health care programs. The firm's health care practice has helped more than 47 state Medicaid programs"

- 18 offices providing services to 47 state clients and CMS supporting various programs including the Medicaid Electronic Health Records (EHR) Incentive Program
- Contracted by the Department of Community Health to conduct post payment auditing services related to Medicaid EHR incentive payments
- www.mslc.com

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WHAT IS THE GOAL OF THE POST PAYMENT AUDIT?

The goal of the post payment audit is to ensure the provider is in **compliance** with the program requirements.

The goal is NOT to recoup incentive payments.

POST PAYMENT PROCESS

- Audit notification letter is sent to provider/hospital contact ***(mail /email)*** and includes the documentation Request – Who?, What?, When?, Where?, and How?

- A hard-copy notification letter is mailed to the practice and/ or an email with a copy of the notification letter is sent to the practice

- Always collect and submit system generated documentation **securely** to Myers and Stauffer

- Myers and Stauffer will create a free user account to submit files through Secure File Transfer Protocol sit (SFTP)

POST PAYMENT PROCESS

- Myers and Stauffer will review the documentation, may make follow-up requests, and then submit results to the State.

- A findings letter is sent to the provider with the results. (Pass or Fail)

- The state's appeal process is available should the provider disagree with any negative findings.

POST PAYMENT PROCESS

- **Desk Review Procedures -** Agreed-upon procedures performed by Myers and Stauffer for purposes of obtaining and analyzing documentation from Eligible Professionals in accordance with the Department's post-payment process to support the provider's eligibility for the Georgia Medicaid Electronic Health Record Incentives Program. Desk Review Procedures are conducted at the offices of Myers and Stauffer.

- **On-Site Review Procedures –** Agreed-upon procedures performed by Myers and Stauffer for purposes of obtaining and analyzing documentation from Eligible Professionals in accordance with the Department's post-payment process to support the provider's eligibility for the Georgia Medicaid Electronic Health Record Incentives Program. On-site Review Procedures will be conducted at the request of the Department or when results from the Desk Review Procedures are inconclusive. On-site Review procedures are conducted at the provider's location and in the offices of Myers and Stauffer.

WHAT DO YOU NEED TO DOCUMENT?

Patient Volume - *(AIU/MU)*

- That the **30% eligibility requirement** is met (20% for pediatricians with reduced payment)

- For **groups**, that all patient encounters from all providers in the group have been included. In Georgia, a group is defined as all locations and providers under a TIN.

- If there are any **physician assistants** that received a payment, that the group is PA lead.

- If **needy encounters** are included in the numerator, that all providers receiving an incentive payment practice predominantly at an FQHC/RHC.

- That providers are not **hospital-based**.

- That **patient volume** is calculated using encounters. (a unique patient for a unique date of service)

WHAT DO YOU NEED TO DOCUMENT?

<u>Modified Stage 2</u> - *(MU)*

- That 10 Objective measures have been met ***(This includes the Security Risk Analysis and includes the one public health objective.)***
- That you meet the requirements for taking any exclusions claimed
- That patient volume eligibility requirements have been met

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WHAT DOCUMENTATION SHOULD I SUBMIT?

- Encounter data in Microsoft Excel file (preferred)
- Meaningful Use Summary report from EHR software
- Support for choosing MU exclusion(s)
- Screenshot/Screengrab (images)

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WHAT DOCUMENTATION SHOULD I SUBMIT?

All documentation should be:

- For the appropriate time period
- Include data for all appropriate provider(s)
- Legible
- Complete

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WHAT KINDS OF DOCUMENTATION MUST I SUBMIT?

For Patient Volume, include dates of service, provider name, unique patient ID or patient name, information to show Medicaid eligibility for Medicaid encounters. This documentation could be a detailed billing report or appointment listing.

For groups, a Payroll listing, timesheets *to show all providers were included in patient volume calculation.*

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WHAT KINDS OF DOCUMENTATION MUST I SUBMIT?

Meaningful Use – Modified Stage 2

- MU Dashboard/Summary – displays the percentage-based measures (Objectives and CQMs)
- Excluded objectives measure support (does not include alternate exclusion(s))
- Yes (enabled) objectives
- Security Risk Analysis (Objective 1)

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AUTHORITY

THE HIPAA PRIVACY RULE - U.S. Department of Health and Human Services

Health Oversight Activities. Covered entities may disclose protected health information to health oversight agencies (as defined in the Rule) for purposes of legally authorized health oversight activities, such as **audits** and investigations necessary for oversight of the health care system and government benefit programs.

WHAT IF I CANNOT SUPPORT AN AUDIT OR FAIL AN AUDIT

- A findings letter will be sent to notify you of the audit results
- DCH approves audit findings before letter is sent
- Findings letter contains details if you agree or disagree with audit findings
- If you disagree with the audit findings, a request for Initial Administrative Review must be submitted within thirty (30) calendar days of the date of the findings letter.

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DO'S FOR A POSITIVE AUDIT EXPERIENCE

- Maintain a copy of all documentation to support encounter volume (for both the Medicaid encounter volume and Total Encounter volume)

  A) Maintain access to all records even if you change vendors

  B) Maintain back-up files if you change vendors

  C) Maintain access to records if hard-copies (complete data set)

  D) Maintain a summary which ties to the detail, if supporting documentation is hard-copy

DO'S FOR A POSITIVE AUDIT EXPERIENCE

- Upload detailed support using secure FTP account
- Communicate with Myers and Stauffer staff via email and phone
- Meet deadlines as requested, if deadline cannot be met communicate with Myers and Stauffer team immediately

DO'S FOR A POSITIVE AUDIT EXPERIENCE

- Know the definition of an **encounter:**

1) Any service rendered to an individual patient on any one day where Medicaid or a Medicaid demonstration grant paid for all or part of the services or all or part of the premiums, copayments or cost-sharing.

2) Includes services rendered to Medicaid CMO members and Medicaid FFS members.

3) Services rendered by students or those authorized to provide services directly, such as nurses, and supervised by the billing provider/ EP may be counted as encounters by the billing provider (EP).

DO'S FOR A POSITIVE AUDIT EXPERIENCE

- To be considered "Medicaid" volume the patient had to be **Medicaid eligible during the date of service**. This includes zero paid and denied claims which includes:

1) Claims denied because the Medicaid beneficiary maxed out the service limit

2) Claims denied because the services were not covered under the State's Medicaid program

3) Claims paid at $0 because another payer's payment exceeded the Medicaid payment

4) Claims denied because the claims were not submitted timely

DO'S FOR A POSITIVE AUDIT EXPERIENCE

- Know the **Eligibility Percentage Calculation:**

Medicaid Percentage Calculation:

Numerator = Medicaid less CHIP

Denominator = All Payers *(includes Medicaid and CHIP)*

DO'S FOR A POSITIVE AUDIT EXPERIENCE

- Know the difference between **Group and Individual Proxy**

Group Proxy:

Incentive payments are for individual providers based on the provider's NPI. However, EPs practicing in clinics and group practices (including FQHCs and RHCs) are allowed to use the group practice or clinic Medicaid patient volume (or Needy Individual patient volume, insofar as it applies) and apply the practice or clinic volume calculation to all Eligible Professionals in the practice under the following conditions:

a) The clinic or group practice's patient volume is **appropriate as a patient volume methodology** calculation for the Eligible Professional. For example, if the Eligible Professional only sees Medicare, commercial or private pay patients, this is not an appropriate calculation. A group practice's patient volume is appropriate for an Eligible Professional only if Medicaid (Title XIX) patients were served by the Eligible Professional during the 90-day period.

b) There is an **auditable data source** to support the clinic or group practice's patient volume determination.

DO'S FOR A POSITIVE AUDIT EXPERIENCE

Group Proxy continued:

c) All Eligible Professionals in the clinic or group practice must use the **same methodology** for the payment year. In other words, clinics or group practices could not have some Eligible Professionals using individual patient volume for patients seen at the clinic or group practice, while others use the clinic- or group practice-level data.

d) The clinic or group practice must use the **entire practice's patient volume and not limit it** in any way. When electing to use group practice patient volume, the entire practice's patient volume must be included. This includes the services rendered for all providers within the group practice, regardless of provider type or eligibility status.

e) If the Eligible Professional works in a clinic or group practice, as well as outside the clinic or group practice, then the patient volume calculation includes only those **encounters associated with the clinic or group practice**, and not the Eligible Professional's outside encounters.

DONT'S FOR A POSITIVE AUDIT EXPERIENCE

- Don't ignore the notification letter
- Don't ignore email and phone messages
- Don't discard hard-copies until 6 years from the date of the Medicaid incentive payment
- Don't limit or cut off access to records from prior system(s)

SECURITY RISK ANALYSIS TIPS – OBJECTIVE 1

- Conducting or reviewing a security risk analysis to meet the standards of Health Insurance Portability and Accountability Act of 1996 (HIPAA) Security Rule is included in the meaningful use requirements of the Medicaid EHR Incentive Program.

- You are required under the HIPAA Security Rule to conduct an accurate and thorough analysis of the potential risks and vulnerabilities to the confidentiality, integrity, and availability of ePHI.

- Once you have completed the risk analysis, you must take any additional "reasonable and appropriate" steps to reduce identified risks to reasonable and appropriate levels. (45 CFR 164.308(a)(1)(ii)).

- Conducting a security risk analysis is required when certified EHR technology is adopted in the first reporting year. In subsequent years, or when changes to the practice or electronic systems occur, a review must be conducted.

- Meaningful use does not impose new or expanded requirements on the HIPAA Security Rule.

SRA CONTINUED – OBJECTIVE 1

- Proper Time Period – Program Year 2014 and beyond the SRA has to be completed by the date of attestation
- Physical Safeguards
- Administrative Safeguards – Do not limit SRA to just the EHR system
- Technical Safeguards – Controls on access to the EHR system and other sources of ePHI
- Asset Inventory – identify where all e-PHI is stored, received, maintained or transmitted

SRA CONTINUED – OBJECTIVE 1

- Threats/Vulnerabilities
- Current security measures
- Likelihood of threat occurrence
- Potential impact of threat occurrence
- Final Report
- Action Plan
- Many acceptable methods

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HOW LONG SHOULD I KEEP MY DOCUMENTATION?

- All documentation to support meaningful use is **REQUIRED** to be kept for a minimum of **SIX YEARS after date of attestation**.

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CONTACT INFORMATION

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QUESTIONS