May 30, 2019

**Case Number** **9199292929**

NPI: 1234567890

Dr. Jane Doe

123 ABC Lane

Raleigh, NC 27610

**Re: NC Medicaid EHR Incentive Program Notice of Desk Audit**

Dear Dr. Jane Doe:

This letter is to inform you that the NC Medicaid Electronic Health Record (EHR) Incentive Program (the Program) Investigation Teamintends to perform a desk audit to review documentation supporting your Program Year 2018 Stage 3 Meaningful Use (MU) attestation for the NC Medicaid EHR Incentive Program.

In accordance with 42 CFR §495.300, which implements section 4201 of the American Recovery and Reinvestment Act of 2009, NC Medicaid administers this program and issues incentive payments to those eligible professionals (EPs) who adopt, implement, or upgrade to a certified EHR technology and demonstrate the meaningful use of that technology.

Pursuant to 42 CFR § 495.368, states must comply with federal requirements to ensure providers who attest for Medicaid EHR incentive payments do so in accordance with the Centers for Medicare and Medicaid Services’ (CMS) rules and regulations. The Program Investigation Team serves the purpose of detecting improper payments and takes corrective action in the case improper payments were issued.

NC Medicaid, or its authorized agent, is authorized by Section 1902(a) (27) of the Social Security Act and Federal Regulation 42 CFR § 431.107 to access patient medical records for the purposes directly related to the administration of a Medicaid-administered program. This includes any information related to your reported patient volume. In addition, when applying for Medicaid benefits, each beneficiary signs a release which authorizes access to her/his Medicaid records by appropriate regulatory authorities. Therefore, program participants do not need special permission to release records to NC Medicaid or its authorized agents.

To facilitate this desk audit, please complete the questionnaire, which begins on page three. The questionnaire is intended to gather information regarding the practice and strategy used specifically by you, the attesting provider, to meet Stage 3 MU. In addition to providing responses to the requested information in the questionnaire, please provide relevant documentation to support your responses for the applicable MU Objectives and CQMs.

Please send the completed questionnaire and supporting documents via secure email to [NCMedicaid.HITInvestigator@dhhs.nc.gov](mailto:NCMedicaid.HITInvestigator@dhhs.nc.gov) by June 7, 2019 in order to avoid recoupment of your Program Year 2018 EHR incentive payment.

We suggest submitting this information as soon as possible in case there are issues with your documentation that need to be addressed before the deadline. Note that submitting improper or incomplete documentation does not alter the deadline.

**If you have any urgent questions or concerns regarding this audit**, please contact Ryan Armstrong by phone at 919-527-7228 or via email at [NCMedicaid.HITInvestigator@dhhs.nc.gov](mailto:NCMedicaid.HITInvestigator@dhhs.nc.gov).

Thank you,

Ryan Armstrong

Program Investigator

NC Medicaid EHR Incentive Program

North Carolina Department of Health and Human Services

**Program Year 2018 Questionnaire**

**1. Demographics** **documentation.** [delete the ones that do not apply]

Please submit the demographics documentation requested below for your attested-to patient volume period of 10/1/2017 to 12/29/2017.

1. Patient-level reports to substantiate **total patient volume** (reported denominator). Please send this information on an excel spreadsheet. The report of total encounters must include for each encounter a unique identifier for the patient, date of service, and unique identifier for rendering provider. This will contain PHI and must be sent via secure email.
2. Patient-level reports to substantiate attested **Medicaid-paid patient volume** (reported Medicaid-paid portion of numerator). Please send this information on an excel spreadsheet. Reports of Medicaid-paid encounters must include for each encounter the patient’s unique Medicaid identifier (MID), date of service, rendering provider NPI, and practice billing NPI. This will contain PHI and must be sent via secure email.
3. Patient-level reports or other documentation to substantiate attested **Medicaid-enrolled zero-pay patient volume** (zero-pay portion of reported numerator). Please send this information on an excel spreadsheet. Reports of Medicaid-enrolled zero-pay encounters must include for each encounter the patient’s unique Medicaid identifier (MID), date of service, and rendering provider NPI. If reporting a denied claim as part of your zero-pay encounters, please specify why the claim was denied. This report will contain PHI and must be sent via secure email.
4. Patient-level reports or other documentation to substantiate attested **no pay and sliding scale patient volume** (no pay and sliding scale portion of reported numerator). Please send this information on an excel spreadsheet. Reports of no pay and sliding scale encounters must include for each encounter a unique identifier for the patient (MID for Medicaid patients and name with date of birth for non-Medicaid patients), date of service, and rendering provider NPI. This report will contain PHI and must be sent via secure email.
5. Patient-level reports or other documentation to substantiate that group methodology was appropriate (e.g., demonstrate that your patient volume was in line with the group’s patient volume. Note that if you saw only Medicare, commercial, or self-pay patients, then the group’s patient volume would not have been an appropriate calculation).
6. Submit documentation to support your claim that you furnished services at a Federally Qualified Health Center or Rural Health Clinic that is led by a PA by proving (1) a PA was the primary provider in a clinic (for example, when there is a part-time physician and full-time PA, we would consider the PA as the primary provider); (2) a PA was a clinical or medical director at a clinical site of practice; or, (3) a PA is an owner of an RHC.
7. We estimate that the average provider has approximately 1,260 encounters within a 90-day period. You have reported less than 10 encounters in a 90-day period for your patient volume denominator. We understand there are valid reasons for having a small denominator. Among other factors, providers in certain specialties or at teaching hospitals may see fewer patients than the estimated average. You may have also decided to report on only one practice location, which is acceptable for the purposes of calculating patient volume. Please provide a brief memo on practice letterhead explaining the number of encountersyou reported.

**2.** **MU Objectives**

Please submit the requested documentation for the four MU Objectives listed below for your attested MU reporting period of 1/1/2018 to 3/30/2018 or explain why an exception was taken (where applicable). Please note, the documentation should be specific to you as the attesting provider.

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| **Core Measure** | **Question** | **Response** |
| # 1 ‐ [Protect Electronic Health Information](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEPStage3_Obj1.pdf) | Please submit a copy of 1) the risk assessment performed and 2) your plan to implement security updates as necessary and correct identified security deficiencies as part of its risk management process. |  |
| # 2 ‐ [e‐Prescribing (eRx)](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEPStage3_Obj2.pdf) | Please submit proof that permissible prescriptions **you wrote** were transmitted electronically using certified EHR technology. This can be demonstrated by a screenshot of a prescription being sent/received electronically. |  |
| # 7 – [Health Information Exchange](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEPStage3_Obj7.pdf) | Please provide 1) a screenshot from your EHR of a summary of care record **you** created and 2) proof that you **sent** the summary of care record electronically to a receiving provider, such as confirmation of date/time sent or receipt notice from receiving provider. |  |
| # 8 – [Public Health and Clinical Data Registry Reporting](https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/MedicaidEPStage3_Obj8.pdf) (Measure 1 – Immunization Registry Reporting) | If provider selected Active Engagement Option 1 – (Completed Registration to Submit Data): Please send a copy of the confirmation email for the completed registration sent to **you** from the NC Department of Public Health.  If provider selected Active Engagement Option 2 – Testing and Validation: Please sent a copy of **your** response to the NC Department of Public Health’s request to test and validate the electronic submission of **your** data.  If provider selected Active Engagement Option 3 – Production: Please send a screenshot of confirmation from the NC Department of Public Health showing **your** successful electronic submission of production data. |  |

**3. Clinical Quality Measures (submit documentation for only three measures)**

In Program Year 2018, providers were required to report on six of 53 CQMs. Please submit patient-level system generated documentation, for your attested CQM reporting period of 8/24/2017 to 11/21/2017, specific to you as the attesting provider, which illustrates that you met the requirements for three CQMs on your Program Year 2018 attestation. Resending the CQM summary that was submitted with the original attestation does not meet this requirement.

**4. Certifying Signature**

I, Dr. Jane Doe, certify that the responses documented in this questionnaire and the supporting documentation provided is accurate to the best of my knowledge.

Signature:

Date: