Desk Audit Questionnaire Directions

Please complete each applicable objective by including your responses in the "EP's Responses" column of the questionnaire. Additionally, as applicable, for each objective, please provide documentation supporting each of your responses.

General Information

The purpose of this section is to understand basic information about your practice and the strategy employed to meet Modified Stage 1 MU requirements. Information obtained in this section is used to provide additional context to your attestation during the review process.

Objective		EH's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
1. Identification Information	Name:			
	NPI:			
	CCN:			
2. Patient Volume Percentage Requirement (10% for all Hospitals except Children's Hospitals who do not have a patient volume requirement). Note that patients may only be counted once per day.	**Reporting Period** (patient volume date range):			
	EP Attestation Numerator (the total number of Medicaid encounters the provider treated in the reporting period):			
	Medicaid Out-of-State (list):			
	West Virginia Medicaid Fee-For-Service (FFS):			
	West Virginia Medicaid Managed Care (MCO):			
	Total Medicaid Encounters:			
	EP Attestation Denominator (the total number of encounters the provider treated in the reporting period):			
	Total Patient Encounters:			

Objective		EH's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	Briefly describe the procedures performed to determine patient volume in your practice. Please also explain how patient volume is determined if you are practicing in multiple locations or groups. Please provide documentation to support your response. *Examples of acceptable forms of supporting documentation include: EHR/ PM reports, records with signed attestations from a Director/Supervisor, and documentation supporting the patient volume calculations for each practice location.*	Procedures: Supporting documentation provided? ☐ Yes ☐ No		
	Please provide a patient volume system-generated report in a Microsoft Excel format with a system stamp showing it is generated from within your EHR **AND** a screenshot of the EHR's system settings. **Please be sure your documentation includes the following: name of patient, date of birth, social security number, insurance type, provider who treated the patient, date of service, Medicaid ID, and the state in which the visit occurred and was billed.**	Supporting documentation provided? ☐ Yes ☐ No		
3. Certified EHR Technology (CEHRT)	What is your CEHRT number?			
	For year being attested to **(2015)**, provide details of CEHRT software maker, software version, and documentation showing date of CEHRT implementation.			

Objective		EH's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	Please provide documentation showing your legal or financial commitment to the CEHRT. This can include: bill(s) of sale, receipts, contracts, maintenance agreements, licenses, canceled checks, or other documentation.	Supporting documentation provided? ☐ Yes ☐ No		
	Does your CEHRT meet the 2014 standards?	☐ Yes ☐ No		
	Is your CEHRT the same one you attested with in prior years?	☐ Yes ☐ No		

Attestation

The following questions are related to specific measures, which you are required to meet in order to achieve Modified Stage 2 MU. All measures must be answered and supporting documentation provided.

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
2.1 Measure – Protect Electronic Health Information Conduct or review a security risk analysis in accordance with the requirements in 45 CFR 164.308(a)(1), including addressing the security (to include encryption) of ePHI created or maintained by CEHRT in accordance with requirements under 45 CFR 164.312(a)(2)(iv) and 45 CFR 164.306(d)(3), and implement security updates as necessary and correct identified security deficiencies as part of the eligible hospital or CAH's risk management process. Many EH's have contracted with third parties to conduct a security risk assessment.	Who performed the security risk analysis of your CEHRT and what criteria/standard were used?			
	Provide a copy of the risk assessment that should include a **final report**, **asset inventory**, and **date** of assessment (which should fall within the attestation calendar year).	Supporting documentation provided? ☐ Yes ☐ No		
	Were deficiencies identified?	☐ Yes ☐ No		
	If yes, please list the deficiencies and describe the steps taken to address the identified deficiencies in a timely manner. Please note, risk assessments in consecutive years should be provided, along with any other supporting documentation available, to assist in verifying that identified deficiencies were remediated.			
2.2 Measure – Clinical Decision Support (CDS) Rule Eligible Hospitals (EHs) must satisfy both of the following parts in order to meet the objective:	Please describe the workflow used to meet the Stage 1 criteria of implementing 5 clinical decision support interventions. Include a description of how your EHR tracks compliance with this rule.			
	Please provide a screenshot from your system that shows how your CEHRT tracks compliance.	Supporting documentation provided? ☐ Yes		

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
Part 1 – Implement 5 CDS interventions related to four or more clinical quality measures (CQMs) at a relevant point in patient care for the entire EHR reporting period. Absent 4 CQMs related to an eligible EH's scope of practice or patient population, the CDS interventions must be related to high-priority health conditions. **Alternate Part 1**: For an EHR reporting period in 2015 only, an EH or CAH that is scheduled to participate in Stage 1 in 2015 may satisfy the following in place of part 1: Implement 1 clinical decision support rule relevant to specialty or high clinical priority, or high priority hospital condition, along with the ability to track compliance with that rule. **Part 2** – The eligible hospital or CAH has enabled and implemented the functionality for drug-drug and drug-allergy interaction checks for the entire EHR reporting period.	Please ensure it is evident that the CDSR support is from the EHR date range.	☐ No		
	Please provide documentation showing that your system automatically and electronically indicates drug-drug and drug-allergy contraindications. This can be in the form of a system screenshot dated during the PI reporting period. Please ensure it is evident that both the drug-drug and drug-allergy support is from the EHR date range. Please note, the CDSR measure is different than the CQM requirement. These need to aid directly in clinical decision making at a relevant point in patient care and improve patient care in some manner.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
2.3 Measure – Computerized Provider Order Entry (CPOE) An eligible hospital (EH), through a combination of meeting the thresholds and exclusions (or both), must satisfy all three measures for this objective below:				

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
2.3 A – Medication Orders More than 60 percent of medication orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry. **Alternatie Measure:** For Stage 1 providers in 2015, more than 30 percent of all unique patients with at least one medication in their medication list admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period have at least one medication order entered using CPOE; or more than 30 percent of medication orders created by the authorized providers of the eligible hospital or CAH for patients admitted to their inpatient or emergency departments (POS 21 or 23) during the EHR reporting period are recorded using computerized provider order entry.	Please provide a screenshot or a report from the CEHRT system showing that medication orders are recorded in your CEHRT.	Supporting documentation provided? ☐ Yes ☐ No		
	Please indicate how your EHR determined your denominator values for number of medication orders Please provide documentation showing that the threshold of the orders recorded using your CEHRT were met.	Supporting documentation provided? ☐ Yes ☐ No		
2.3 B – Laboratory Orders	Did you qualify for the alternate exclusion? (EHs must be scheduled to be in Stage 1 in 2015/2016 to claim this exclusion)	☐ Yes ☐ No		

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
More than 30 percent of laboratory orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	If yes, please provide documentation that supports the alternate exclusion criteria.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	Please provide a screenshot or a report from the CEHRT system showing that laboratory orders are recorded in your CEHRT.	Supporting documentation provided? ☐ Yes ☐ No		
	Please indicate how your EHR determined your denominator values for number of lraboratory orders Please provide documentation showing that the threshold of the orders recorded using your CEHRT were met.	Supporting documentation provided? ☐ Yes ☐ No		
2.3 C – Radiology Orders More than 30 percent of radiology orders created by the authorized providers of the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) during the EHR reporting period are recorded using CPOE.	Did you qualify for the alternate exclusion? (EHs must be scheduled to be in Stage 1 in 2015/2016 to claim this exclusion)	☐ Yes ☐ No		
	If yes, please provide documentation that supports the alternate exclusion criteria.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	Please provide a screenshot or a report from the CEHRT system showing that radiology orders are recorded in your CEHRT.	Supporting documentation provided? ☐ Yes ☐ No		

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	Please indicate how your EHR determined your denominator values for number of radiology orders Please provide documentation showing that the threshold of the orders recorded using your CEHRT were met.	Supporting documentation provided? ☐ Yes ☐ No		
2.4 Measure – Electronic Prescribing (eRx) More than 10 percent of hospital discharge medication orders for permissible prescriptions (for new and changed prescriptions) are queried for a drug formulary and transmitted electronically using certified electronic health record technology (CEHRT).	Did you qualify for an exclusion?	☐ Yes ☐ No		
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	Did you qualify for the alternate exclusion? (EHs must be scheduled to be in Stage 1 in 2015/2016, or if they are scheduled to demonstrate Stage 2 but did not intend to select the Stage 2 eRx objective to claim this exclusion)	☐ Yes ☐ No		
	If yes, please provide documentation that supports the qualification of the alternate exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	Please provide the policy and procedure of ordering electronically with the use of e-Prescriptions.	Supporting documentation provided? ☐ Yes ☐ No		

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	Please provide a screenshot of the capabilities of e-Prescribing ordering being implemented and used.	Supporting documentation provided? ☐ Yes ☐ No		
	Please provide documentation showing that the threshold of the prescriptions recorded using your CEHRT were met.	Supporting documentation provided? ☐ Yes ☐ No		
	Who are the primary recipients (maximum of 5) of e-Prescriptions authorized you and members of your facility (i.e. Pharmacy, or internal)? Please include an address or other unique identifier of the recipient	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	If applicable, please provide documentation showing that your system automatically and electronically indicates drug formulary checks. This can be in the form of a system screenshot dated during the PI reporting period.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
2.5 Measure – Health Information Exchange The EH that transitions or refers their patient to another setting of care or provider of care must (1) use certified electronic health record technology (CEHRT) to create a summary of care record; and (2) electronically transmit such summary to a receiving provider for more than 10 percent of transitions of care and referrals.	Did you qualify for the alternate exclusion? (EHs must be scheduled to be in Stage 1 in 2015 to claim this exclusion)	☐ Yes ☐ No		
	If yes, please provide documentation that supports the qualification of the alternate exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	What information is included with a summary of care record/health information exchange? How does your EHR determine a transition of care?			

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	Please provide the following information regarding the attempted exchange of summary of care information: • Entity with whom the electronic summary of care was transmitted to: • EHR used by the receiving Entity: Alternatively • Did you test with the CMS designated test EHR? • Date:	Result of test/exchange: ☐ Successful ☐ Unsuccessful		
	Please provide copies of your test results or an example of an exchange with another provider that include the following information regarding the attempted exchange of clinical information:			
	Entity with whom the electronic summary of care/health information exchange was transmitted to:			
	CEHRT used by the receiving Entity:			
	Alternatively:			
	Did you test with the CMS-designated test CEHRT?	☐ Yes ☐ No		
	If yes, what was the date?			
	If yes, what were the test results?			
	Supporting documentation provided?	☐ Yes ☐ No		

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
2.6 Measure – Patient-Specific Education Resources More than 10 percent of all unique patients admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23) are provided patient specific education resources identified by CEHRT.	Did you qualify for the alternate exclusion? (EHs must be scheduled to be in Stage 1 in 2015 to claim this exclusion)	☐ Yes ☐ No		
	If yes, please provide documentation that supports the qualification of the alternate exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	What clinically relevant information is used to identify patients who should receive patient-specific educational materials? What is the mechanism in place to provide patients an electronic copy of their health information (i.e. Physical media, Patient Portal, etc.) after discharge? How do you determine the number of patients that view online/download/transmit their health information after discharge?			
	Please provide a formal policy and a screenshot from your system showing an example of clinically relevant information that you are tracking to identify patients who should receive patient-specific educational materials. Also provide support showing the required measure threshold was met.	Supporting documentation provided? ☐ Yes ☐ No		
2.7 Measure – Medication Reconciliation	Did you qualify for the alternate exclusion? (EHs must be scheduled to be in Stage 1 in 2015 to claim this exclusion)	☐ Yes ☐ No		

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
The eligible hospital or CAH performs medication reconciliation for more than 50 percent of transitions of care in which the patient is admitted to the eligible hospital's or CAH's inpatient or emergency department (POS 21 or 23).	If yes, please provide documentation that supports the qualification of the alternate exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	What clinically relevant information is included with a medication reconciliation? How does your EHR recognize a Medication Reconciliation?	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	Please provide a screenshot from your system showing medication reconciliation completed for patients transferred to the provider.	Supporting documentation provided? ☐ Yes ☐ No		
2.8 Measure – Patient Electronic Access EPs must satisfy both parts in order to meet this measure: **Part 1** – More than 50 percent of all patients who are discharged from the inpatient or emergency department (POS 21 or 23) of an eligible hospital or CAH are provided timely access to view online, download and transmit to a third party their health information. **Part 2** – For an EHR reporting period in 2015, at least 1 patient who is discharged from the inpatient or emergency department	What is the mechanism in place to provide patients the ability to view online, download, and transmit their health information (e.g., Patient Portal, secure mail)?			
	How do you verify patients have accessed their health information?			
	Please provide a screenshot of the mechanism used and a screenshot from your PI that tracks if patients have accessed their health information.	Supporting documentation provided? ☐ Yes ☐ No		
	Did you qualify for the exclusion for part 2?	☐ Yes ☐ No		
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		

Commented [VC1]: I think each section should ask for the response to part 1, then ask for the response to part 2.

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
(POS 21 or 23) of an eligible hospital or CAH (or patient-authorized representative) views, downloads, or transmits to a third party his or her information during the EHR reporting period.	Did you qualify for the alternate exclusion for part 2? (EHs must be scheduled to be in Stage 1 in 2015 to claim this exclusion)	☐ Yes ☐ No		
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	Please provide documentation of how at least one patient seen during the PI reporting period views, downloads, or transmits to a third party his/her health information during the PI reporting period.	Supporting documentation provided? ☐ Yes ☐ No		
2.9 Public Health Reporting The EH is in active engagement with a public health agency (PHA) to submit electronic public health data from certified electronic health record technology (CEHRT) except where prohibited and in accordance with applicable law and practice. Below are the three measure options under the public health reporting measure:				
2.9 A – Measure Option 1 – Immunization Registry Reporting The eligible hospital or CAH is in active engagement with a public health agency to submit immunization data.	Did you qualify for an exclusion?	☐ Yes ☐ No		
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	If attesting yes to Immunization Registry Data Submission, please provide the following required documentation:			
	Registry Name:			

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	Ongoing submission?	☐ Yes ☐ No		
	If yes, disregard the following questions on testing. If no, what was your date of test submission?			
	Outcome of test submission:	☐ Successful ☐ Unsuccessful		
	If test was successful, was a follow-up submission of live data performed?	☐ Yes ☐ No		
	If no, please explain why not?			
2.9 B – Measure Option 2 – Syndromic Surveillance Reporting The eligible hospital or CAH is in active engagement with a public health agency to submit syndromic surveillance data.	Did you qualify for an exclusion?	☐ Yes ☐ No		
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	If attesting yes to Syndromic Surveillance Data Submission, please provide the following required documentation:			
	Public Health Agency Name:			
	Ongoing submission?	☐ Yes ☐ No		
	If yes, disregard the following questions on testing. If no, what was your date of test submission?			
	Outcome of test submission:	☐ Successful ☐ Unsuccessful		

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
	If test was successful, was a follow-up submission of live data performed?	☐ Yes ☐ No		
	If no, please explain why not?			
2.9 C – Measure Option 3 – Specialized Registry Reporting The eligible hospital or CAH is in active engagement to submit data to a specialized registry.	Did you qualify for an exclusion?	☐ Yes ☐ No		
	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	If attesting yes to Specialized Registry Data Submission, please provide the following required documentation:			
	Public Health Agency Name:			
	Ongoing submission?	☐ Yes ☐ No		
	If yes, disregard the following questions on testing. If no, what was your date of test submission?			
	Outcome of test submission:	☐ Successful ☐ Unsuccessful		
	If test was successful, was a follow-up submission of live data performed?	☐ Yes ☐ No		
2.9 C – Measure Option 4 – Electronic	Did you qualify for an exclusion?	☐ Yes ☐ No		

Objective		EP's Responses	Auditor's Comments (For State Use Only)	W/P Reference (For State Use Only)
Reportable Laboratory Result Reporting The eligible hospital or CAH is in active engagement with a public health agency to submit electronic reportable laboratory (ELR) results.	If yes, please provide documentation that supports the qualification of an exclusion.	Supporting documentation provided? ☐ Yes ☐ No ☐ N/A		
	If attesting yes to Specialized Registry Data Submission, please provide the following required documentation:			
	Public Health Agency Name:			
	Ongoing submission?	☐ Yes ☐ No		
	If yes, disregard the following questions on testing. If no, what was your date of test submission?			
	Outcome of test submission:	☐ Successful ☐ Unsuccessful		
	If test was successful, was a follow-up submission of live data performed?	☐ Yes ☐ No		

EH Certification

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

Contact Name: _____ Contact Email:_____

EP Signature/Title: _____ Date: _____