



Eligible Hospitals: Pre-Attestation and Audit Checklist Tool

Client agrees to share pertinent documents with REACH, should REACH require it to support an audit of our work with clients. Client also acknowledges that this document is designed to help our clients organize documentation that will support them in case of an audit. REACH's assistance and guidance provided in this document does not ensure you will pass an audit, or that auditors will not ask for additional documentation not anticipated by REACH.

Based on CMS Audit Information as of 07.26.12: [Web link to audit detail and background](#)

Step 1: Review the two CMS audit guidance PDF documents at the links below. This is the best and official source of information.

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_Audit_Overview_FactSheet.pdf

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_SupportingDocumentation_Audits.pdf

The following link is an example of an audit letter that you would receive if your organization is selected. CMS and its auditor may also contact you via email.

<http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/SampleAuditLetter.pdf>

Step 2: Review this document and use it as a checklist and supporting document to the CMS PDF document.

This document is intended to guide you through questions and consideration prior to commencing your Meaningful Use reporting period. The document is also useful in preparing for **audit requirements**. REACH encourages you to use the 'Item Addressed' column as a checklist for completion or at least acknowledgement that each item has been addressed. If you are attesting for EPs who work in multiple locations with Certified EHR Technology (CEHRT), the attestation needs to combine numerators and denominators from all CEHRT.

Additional Audit Information:

Medicare:

CMS has provided guidance during a webinar that once an audit has been initiated, there is no opportunity for CMS to change any data that has been submitted via the attestation process. If you have any concern or detect errors that were made or submitted to CMS, you must contact CMS BEFORE receiving an audit letter from Figliozzi & Co. Also, if the audit firm detects any errors or issues, current information indicates that EHR Incentive dollars are being recovered as a whole, not partial amounts. When an audit is failed, it is deemed the same as not having complied with MU for that year (there is no 'do-over' opportunity).

Medicare audit appeals:

Scroll to the bottom of this document for a toll free number and brief paragraph on the appeals process:

http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_Audit_Overview_FactSheet.pdf

Medicaid:

Medicaid audits will be conducted at the state level and the entities responsible for this may have policies and procedures that do not conform to what has been reported for the federal Medicare program as described above. The experience so far for the state of MN (year one, which is Adopt/Implement/Upgrade and is not the same as being a 'Meaningful User') is that the company, CGI, contracted by the MN Dept. of Human Services, will request additional info or documents that will help substantiate or complement information that has already been submitted.

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Topic/Item	Additional detail	Item addressed	Audit Guidance
Preparation / Pre-Attestation			
1. What are your planned attestation period dates?	Try not to choose the final day as the end of your fiscal year. See your REACH consultant for further guidance on date selection.		
2. Have you reviewed your eligibility by looking at the CMS web page for this?	Visit the CMS hospital eligibility web page .		
3. Where are you in the process of implementing Meaningful Use (MU) reports that tell you the percentage of compliance with MU requirements?	Be certain that you understand where your EHR is pulling data from which supports the MU report. You vendor can provide guidance, including for Clinical Quality Measure questions.		Create and retain (paper and/or electronic) reports out of your Electronic Health Record (EHR) to save in your audit file after attesting to MU.
4. Have you assembled a team that monitors the reports and communicates shortfalls to those responsible?	Check your MU report frequently and insure that providers are educated about documenting in the EHR to comply with MU objectives.		
5. Will your hospital qualify under Medicare or Medicaid or both?	Be sure that you have selected the 'both' radio button in the CMS registration website.		
6. Have you registered your Eligible Hospital (EH) on the Centers for Medicare & Medicaid Services (CMS) site (applies to both Medicare and Medicaid participation)? Do you have the following?: - NPI Number - NPPES User ID and Password - CCN (CMS Certification Number)	NOTE: Your hospital should have a proxy set up in the CMS Identity and Access Management System (I&A System) web user account with a User ID and Password. Help Desk for CMS Registration Problems: (888) 734-6433 Link to CMS Website Help Desk for MEIP MN program: (855) 676-0366 Link to MEIP website .		

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Preparation / Pre-Attestation, continued			
<p>7. Is your hospital participating in the Minnesota EHR Incentive program (Medicaid)?</p>	<p>See the MN ‘MEIP Guidance Manual’ for additional eligibility and enrollment information and actions.</p> <p>Link to MEIP website.</p> <p>Medicaid Year 2 EH MU Guide</p>		<p>If Medicaid is chosen, you will need to retain the ‘prior year or prior ‘12 month rolling period’ Minimum Patient Volume’ calculation that you did and how the data was obtained.</p>
<p>8. Have you purchased all the components of your EHR that were included in the certified version (i.e. all the components needed for a “complete EHR” certification).</p>	<p>If not, have you site-certified what you have as a complete EHR? (Note: most vendors sell ‘complete’ EHRs for EHs to accomplish the MU program)</p> <p>Confirm certification of your system at the ‘Certified Healthcare Product List’s CHPL website.</p> <p>Note: if you didn’t enter your CHPL EHR certification ID at the time of registration, you’ll need to look this for attestation.</p>		<p>Maintain a record of your CHPL EHR Certification ID via screenshot.</p>
General EHR Questions:			
<p>9. Are you able to identify EHR patients?</p>	<p>This is relevant if you are running a hybrid paper/ EHR environment</p>		<p>The MU program has objectives that require you to identify whether the data you are reporting applies to ALL patients or just those that are contained in your EHR. Records should be maintained of how any measures were calculated if you used an data extracted from paper charts.</p>

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<p>Audit specific considerations //Retention of audit information can be electronic or paper. Retain for 6 years.//</p>			
<p>1. Have you established an Attestation File to store information about your decisions, measures and processes in the event of an audit?</p>			<p>Create a paper and/or electronic audit file. Audit documentation request will need to be fulfilled electronically and may require that you scan and create PDF documents.</p>
<p>2. Payment Calculations (Medicare) (See #7 above for Medicaid)</p>	<p>Be sure to review and understand the incentive payment calculations for either Medicare, Medicaid or both programs.</p> <p>Tip Sheet for Medicare Hospitals Medicare Tip Sheet for CAH Payments</p> <p>HealthIT.gov Calculating CAH Payments</p>		<p>Compare your expected total EHR Incentive Payment against amount received from CMS after successful attestation. Retain a record of your calculations for your expected amount. (Same applies for state Medicaid incentive program).</p>
<p>3. MU Reports</p>	<p>Retain all reports for Core &Menu objectives plus Clinical Quality Measures.</p>		<p>Retain copies of report(s) that were used to enter the attestation numerators/denominators into the CMS EHR Incentives Attestation website.</p>
<p>4. Attestation Summary Report (CMS) (5 page pdf format)</p>	<p>CMS offers a comprehensive summary report that you'll need to retain after attesting.</p>		<p>Click on the 'View Summary Information as PDF' button on the CMS attestation website AFTER successful submission.</p> <p>A copy must be sent to your REACH consultant and keep a copy of this for your audit file. It contains a complete summary for all data that you entered into the attestation screens.</p> <p>There is also an attestation 'successful submission' screen (and 'Print' button) that can be printed after submitting your attestation. Talk to your REACH consultant about both options.</p>

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Topic/Item	Additional detail	Item addressed	Audit Guidance
Core Objectives (15 total) – EH			
EH #1: CPOE	<p>Do > 30% of unique patients with at least 1 medication in their med list have at least 1 med ordered via CPOE during the measurement period?</p> <p>2013: May choose to use optional denominator (number of med orders instead of unique patients with >1 med in their med list)</p>		<p>Retain a record of numerator and denominator used for calculating percentage of patients meeting this measure.</p> <p>Retain organizational policies relating to who the organization defines as a “licensed professional”. The policy should also include what to do if a CDS alert is presented. Each state defines a licensed professional individually and the EH needs to make sure only staff who are considered to have this status are doing CPOE.</p> <p>Definition of which roles (MD/NP/PA/RN/LPN/MA) were used to calculate numerator.</p>
EH #2: Drug-Drug & Drug-Allergy Interaction Checks	Do you have drug-drug checks turned on for the entire measurement period?		<p>Screenshot showing that D-D / D-A checking is turned-on/enabled.</p> <p>Each EHR is configured differently and you will need to discuss with your vendor how to substantiate that this function was turned on for the entire reporting period. The guidance on this from CMS has not been completely clear, so check with your HIT consultant for current information on this.</p>
EH #3: Problem List	Do >80% of patients seen have at least one problem or “none” entered as structured data?		<p>Retain a record of numerator and denominator used for calculating percentage of patients meeting this measure.</p> <p>Screenshot showing “no known problems” as a choice</p>

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Topic/Item	Additional detail	Item addressed	Audit Guidance
Core Objectives – EH (continued)			
EH #4: Medication List	Do >80% of patients seen have at least one medication or “none” entered as structured data?		<p>Retain a record of numerator and denominator used for calculating percentage of patients meeting this measure.</p> <p>Screenshot of “no active medications” functionality to demonstrate that your EHR is capable of recording this type of situation in a patient’s medication list.</p>
EH #5: Medication Allergy List	Do >80% of patients seen have at least one allergy or “none” entered as structured data?		<p>Retain a record of numerator and denominator used for calculating percentage of patients meeting this measure.</p> <p>Screenshot of “no known medication allergies” option to demonstrate that your EHR is capable of recording this type of situation in a patient’s allergy list.</p>
EH #6: Demographics	<p>Do >50% of patients seen have preferred language, gender, race, ethnicity, & DOB, recorded as structured data?</p> <p>Whitehouse.gov/OMB/Data on Race & Ethnicity</p>		<p>Retain a record of numerator and denominator used for calculating percentage of patients meeting this measure. Include screenshot of “declined” for each and options for ethnicity.</p>
EH #7: Vital Signs	<p>Do > 50% of patients have vital signs recorded for all unique patients ages 2 and over.</p> <p>2013 (optional, required in 2014): BP/Ht/Wt age 3 vs. age 2; exclusion change: “all or nothing” to BP separate from Ht/Wt.</p>		<p>Retain a record of numerator and denominator used for calculating percentage of patients meeting this measure.</p> <p>Documentation of any EH planning to claim “exclusions” and why.</p>
EH #8: Smoking Status (>13 yrs)	Do > 50% of patients ≥ 13 years and older have smoking status entered as structured data during the measurement period?		<p>Retain a record of numerator and denominator used for calculating percentage of patients meeting this measure.</p>

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Topic/Item	Additional detail	Item addressed	Audit Guidance
Core Objectives – EH (continued)			
EH #12: Electronic Copy of Discharge Instructions	Are you providing an electronic copy of discharge instructions to >50% of all patients (POS 21 or 23) who request it?		<p>Retain a record of numerator and denominator used for calculating percentage of patients meeting this measure.</p> <p>Compile data dictionary (type and source of all data) for discharge summary.</p> <p>Written procedure/diagram of workflow for each medium offered to patients: patient health record (PHR), patient portal, secure e-mail, CD/USB, paper copy, etc.</p>
EH #13: Clinical Data Exchange Note: This measure will no longer be required as of 2013. It will be replaced in Stage 2 (2014 and thereafter) with other health information exchange objectives.	Have you tested your capability of electronic exchange of key information (Ex: d/c summary, procedures, prob list, med list, allergies, test results) at least once during the year?		
	Have you established a P&S Risk Assessment Team?		
	Have you completed a P & S Risk Assessment? (external assistance or an internal work group)		Retain a record of conducting the Privacy and Security Risk Assessment. REACH has a P&S checklist tool to assist you with compliance. Talk to your REACH consultant about this.
	Have you developed a Mitigation Plan to address all the gaps and risks identified during your P & S Risk Assessment?		<p>Retain a copy of your Mitigation Plan containing:</p> <ul style="list-style-type: none"> • List of Issues and/or Risks • Plan to Remediate Issues/Risks • Timeline to Implement Plan • Assignment of Responsibility • Expected Date of Completion • Status

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Core Objectives – EH (continued)			
EH #14: Protect PHI Privacy & Security (P&S) Risk Analysis & Plan	Have you addressed and begun to mitigate all the gaps and risks that you have identified on your Risk Assessment?		Retain documentation of your progress for each item on the above mitigation plan.
Menu Set Objectives – EH (5 out of 10 required with 1 of these 5 being #8 or #9 (public health measure))			
EH #1: Drug formulary checks	Are drug formulary checks ‘switched on’ in your EHR?		Document which formulary is being used (internal, external) Save a screenshot of formulary check
EH #2: Advance Directives	Record advance directives for 50% of all unique patients 65 years and older for POS 21 / inpatient.		Retain a record of numerator and denominator used for calculating percentage of patients 65 and older meeting this measure.
EH #3: Structured Lab Test Results	Did you enter lab results (>40% ordered) as structured data?		Retain a record of numerator and denominator used for calculating percentage of lab tests meeting this measure. Document how data was populated (electronic exchange, manual entry) Document if standard code set used (LOINC, etc.)
EH #4: List of patients by condition	Have you run a patient list report by specific condition?		Copy of report that was generated
EH #5: Patient-specific Education Resources	Did you provide patient-specific education resources (>10% of patients)?		Retain a record of numerator and denominator used for calculating percentage of patients meeting this measure. Document what logic is built into your EHR to generate patient-specific resources (problem list, medication list, lab results, others)

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Menu Set Objectives – EH (5 out of 10 required with 1 of these 5 being #8 or #9 (public health measure))			
EH #6: Medication Reconciliation for Transitions of Care	Did you do medication reconciliation following transition of care (>50% of transitions)?		Retain a record of numerator and denominator used for calculating percentage of care transitions meeting this measure. Policy that defines which encounters are considered “transitions of care” Access to/copy of EHR vendor logic
EH #7: Transition of Care Summary for Transfers or Referrals	Did you provide a Transition of Care Summary (>50% of patient referrals or transfers to another setting)?		Retain a record of numerator and denominator used for calculating percentage of care transitions meeting this measure. Documentation of process for generating summary of care Data dictionary for elements contained in summary of care Documentation of medium used (paper copy, secure transmission, etc.)
EH #8: Immunization Registry Submission *This public health measure OR #9 must be chosen for MN or ND!	Did you submit immunization data (except where prohibited) to your state registry?		Save Screen shot of “upload successful” OR “upload received (but not completely successful)” OR letter/ verification if Public Health agency not ready to receive
EH #9: Reportable Lab Results *This public health measure OR #8 must be chosen for MN or ND!	Submit electronic data on reportable lab results (except where prohibited) to public health agencies. One test of the submission required with continued submission if successful.		Retain a record / screenshot of the test and acknowledgement from public health agency such as a reply email.

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Menu Set Objectives – EH (5 out of 10 required with 1 of these 5 being #8 or #9 (public health measure))			
EH #10: Syndromic Surveillance Data Submission *This public health measure is <u>NOT AVAILABLE</u> in MN or ND!	Did you submit syndromic surveillance (except where prohibited) data to your public health agency?		Save Screen shot of “upload successful” OR “upload received (but not completely successful)” OR letter/ verification if Public Health agency not ready to receive
Clinical Quality Measures (CQMs) – EH – General guidance			
Note: All values reported should be the values produced by the certified EHR technology. A zero numerator for any or all is acceptable if your EHR produces this value.			
Have you selected the Core and/or Alternate as well as additional Alternate Clinical Quality Measures that you will capture and report?	CQMs are reported only...and not evaluated for accuracy by either federal CMS or the state MEIP program. Every effort should be made, however, to utilize the accurate results for quality improvements at your organization.		
Have you generated reports and checked that the results of the CQMs are accurate and make sense?	It’s important to check the accuracy of your chosen CQMs as the way you are documenting data elements that feed into the measures may not sync up with the fields that your vendor’s quality reports may be pulling from.		Print report of CQMs showing numerator, denominator and any ‘exclusion’ values that you are attesting to and retain. Do screenshot of your EHR MU dashboard if report is not available in your system.
Are all the components used to calculate your quality measures certified? (That is: have you implemented the certified CQM reports that are part of the certified version of your EHR?)			
Are your CQM Reports configured and ready for production? If not, when is the projected date?			

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Clinical Quality Measures (CQMs) – EH – General guidance			
Note: All values reported should be the values produced by the certified EHR technology. A zero numerator for any or all is acceptable if your EHR produces this value.			
Have reviewed your workflows to ensure the measures are accurate?	Are you documenting any decisions or workflows that may affect the accuracy or completeness of the CQM reports?		
Have you reviewed your reports to ensure that the numerators and denominators seem reasonable?			
Have you reviewed your reports to ensure that those patients that should be excluded are excluded from the calculations of the numerators and denominators?			
CQM #1 - ED Throughput – NQF 0495: Arrival to Departure			
Median time from emergency department arrival to time of departure from the emergency room for patients admitted to the facility from the emergency department			
	Are you able to record a patient’s arrival time? Who records it?		See general CQM audit guidance above.
	Are you capturing ED Observation patients?		See general CQM audit guidance above.
	Are you capturing mental health patients?		See general CQM audit guidance above.
	Are you capturing the departure time? Who records it?		See general CQM audit guidance above.
	Are you able to exclude ED observation and mental health patients?		See general CQM audit guidance above.

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Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #2 - ED Throughput – NQF 0497: Admission to Departure			
Median time from admit decision time to time of departure from the emergency department for emergency department patients admitted to inpatient status.			
	Are you able to record the time of a decision to admit the patient? Who records it?		See general CQM audit guidance above.
	Are you able to capture the departure time?		See general CQM audit guidance above.
	Are you able to stratify patients as in the previous measure?		See general CQM audit guidance above.
CQM #3 - Stroke -2 NQF 0435: ischemic stroke-DC on antithrombotic			
Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge.			
	Are you able to identify patients with the principal diagnosis code for ischemic strokes?		See general CQM audit guidance above.
	Are you able to capture the discharge antithrombotic prescription?		See general CQM audit guidance above.
	Are you able to identify antithrombotics?		See general CQM audit guidance above.

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Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #3 - Stroke -2 NQF 0435: ischemic stroke-DC on antithrombotic, continued			
Ischemic stroke patients prescribed antithrombotic therapy at hospital discharge, continued			
	<p>Does your sniff test indicate that you are capturing the following exclusions?</p> <ul style="list-style-type: none"> a. Age < 18 b. Length of stay >120 days c. Comfort measures only documented d. Enrolled in clinical trial e. Admitted for elective carotid intervention f. Discharged/transferred to another hospital for inpatient care g. Left against medical advice or discontinued care h. Expired i. Discharged/transferred to a federal healthcare facility j. Discharged/transferred to hospice k. A documented reason for not prescribing anti-thrombotic therapy at discharge 		See general CQM audit guidance above.

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Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM # 4 - Stroke-3 - NQF 0436: Ischemic Stroke - Anticoagulation for A-fib/flutter			
Ischemic stroke patients with atrial fibrillation/flutter who are prescribed anticoagulation therapy at hospital discharge.			
	Are you able to identify patients with the principal diagnosis code for ischemic strokes?		See general CQM audit guidance above.
	Are you able to identify patients with documented A-fib/flutter?		See general CQM audit guidance above.
	Are you able to capture the discharge antithrombotic prescription?		See general CQM audit guidance above.
	Are you able to identify antithrombotics?		See general CQM audit guidance above.
	Does your sniff test indicate that you are capturing the following exclusions? a – k above?		See general CQM audit guidance above.

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Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #5 - Stroke-4 - NQF 0437: Ischemic Stroke - Thrombolytic therapy			
Acute ischemic stroke patients who arrive at this hospital within 2 hours (120 minutes) of time last known well and for whom IV t-PA was initiated at this hospital within 3 hours (180 minutes) of time last known well.			
	Are you able to document the time "last known well"?		See general CQM audit guidance above.
	Are you able to document the patient arrival time?		See general CQM audit guidance above.
	Are you able to document thrombolytic therapy infusion time?		See general CQM audit guidance above.
	Are you able to identify thrombolytics?		See general CQM audit guidance above.
	Are you able to identify patients with the principal diagnosis code for ischemic strokes?		See general CQM audit guidance above.
	<p>Does your sniff test indicate that you are capturing the following exclusions?</p> <ul style="list-style-type: none"> a. Age < 18 b. Length of Stay >120 Days c. Patients discharged by end of hospital day 2 d. Comfort measures only documented on day of or day after arrival e. Enrolled in Clinical Trial f. Admitted for Elective carotid intervention g. Patients with thrombolytic therapy administered at this hospital or within 24 hours prior to arrival h. A documented reason for not administering antithrombotic therapy 		See general CQM audit guidance above.

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Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #6 - Stroke-5 - NQF 0438: Ischemic Stroke – Anti-thrombotic Therapy			
Ischemic stroke patients administered antithrombotic therapy by the end of hospital day two.			
	Are you able to identify patients with the principal diagnosis code for ischemic strokes?		See general CQM audit guidance above.
	Are you able to identify the time antithrombotic therapy was begun?		See general CQM audit guidance above.
	Are you able to identify antithrombotics?		See general CQM audit guidance above.
	Are you able to identify the exclusions above (a – h)		See general CQM audit guidance above.
CQM #7 - Stroke-6 - NQF 0439: Ischemic Stroke – Discharge on Statins			
Ischemic stroke patients with LDL greater than or equal to 100 mg/dL, or LDL not measured, or, who were on a lipid-lowering medication prior to hospital arrival are prescribed statin medication at hospital discharge.			
	Are you able to identify patients with LDL greater than 100?		See general CQM audit guidance above.
	Are you able to identify patients whose LDL was not measured		See general CQM audit guidance above.
	What is the time interval that a previously recorded LDL would be considered not measured?		See general CQM audit guidance above.
	Are you able to identify if a patient was on a lipid-lowering patient prior to hospital arrival?		See general CQM audit guidance above.
	Are you able to identify patients with the principal diagnostic code for ischemic strokes?		See general CQM audit guidance above.

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	Are you able to capture the prescription of a statin medication at discharge?		See general CQM audit guidance above.
	<p>Does your “sniff test” indicate you are capturing the following exclusions:</p> <ul style="list-style-type: none"> a. Age < 18 b. Length of stay >120 days c. Comfort measures only documented d. Enrolled in clinical trial e. Admitted for elective carotid intervention f. No evidence of atherosclerosis g. Discharged/transferred to another hospital for inpatient care h. Left against medical advice or discontinued care i. Expired j. Discharged/transferred to a federal healthcare facility k. Discharged/transferred to hospice l. A documented reason for not prescribing statin medication at discharge 		See general CQM audit guidance above.

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Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #8 - Stroke-8 - NQF 0440: All Stroke – Stroke Education			
Ischemic or hemorrhagic stroke patients or their caregivers who were given educational materials during the hospital stay addressing all of the following: activation of emergency medical system, need for follow- up after discharge, medications prescribed at discharge, risk factors for stroke, and warning signs and symptoms of stroke.			
	Are you able to identify patients with the diagnostic codes for ischemic or hemorrhagic stroke?		See general CQM audit guidance above.
	Are you able to document that the materials were given?		See general CQM audit guidance above.
	Do you record to whom the materials are given?		See general CQM audit guidance above.
	Did materials contain the following elements? <ul style="list-style-type: none"> a. Activation of emergency medical system b. Need for follow-up after discharge c. Medications prescribed at discharge d. Risk factors for stroke e. Warning signs for stroke 		See general CQM audit guidance above.
	Does your sniff test indicate you are capturing the following exclusions: <ul style="list-style-type: none"> a. Age < 18 b. Length of stay >120 days c. Comfort measures only documented d. Enrolled in clinical trial e. Admitted for elective carotid intervention 		See general CQM audit guidance above.

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CQM #9 - VTE-1 - NQF 0441: All Stroke – Assessed for Rehabilitation			
Ischemic or hemorrhagic stroke patients who were assessed for rehabilitation services.			
			See general CQM audit guidance above.
			See general CQM audit guidance above.
			See general CQM audit guidance above.
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CQM #10 - VTE 2 - NQF 0371: Venous Thromboembolism – VTE prophylaxis			
This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after hospital admission or surgery end date for surgeries that start the day of or the day after hospital admission.			
	Are you able to capture that VTE prophylaxis was administered?		See general CQM audit guidance above.
	Are you able to capture the time that VTE prophylaxis was administered?		See general CQM audit guidance above.
	Are you able to document the reason for no VTE administration?		See general CQM audit guidance above.
	What are your acceptable reasons that no VTE prophylaxis was administered?		See general CQM audit guidance above.
	Are you able to capture “the day of or the day after hospital admission?”		See general CQM audit guidance above.
	Are you able to reset the clock for patients who have surgery on the day of or the day after admission?		See general CQM audit guidance above.

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CQM #10 - VTE 2 - NQF 0371: Venous Thromboembolism – VTE prophylaxis			
	<p>Does your sniff test indicate you are capturing the following exclusions:</p> <ul style="list-style-type: none"> a. Age < 18 b. Length of stay < 2 days c. Length of stay >120 days d. Comfort measures only documented on day of or day after hospital arrival e. Enrolled in clinical trial f. Direct admits to intensive care unit (ICU), or transferred to ICU the day of or the day after hospital admission with ICU LOS ≥ one day g. A principal diagnosis of mental disorders h. A principal diagnosis of hemorrhagic or ischemic stroke i. A principal diagnosis of obstetrics j. A principal diagnosis of VTE 		See general CQM audit guidance above.

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CQM #11 VTE 2 - NQF 0372: Venous Thromboembolism – Intensive Care Unit VTE prophylaxis			
This measure assesses the number of patients who received VTE prophylaxis or have documentation why no VTE prophylaxis was given the day of or the day after the initial admission (or transfer) to the Intensive Care Unit (ICU) or surgery end date for surgeries that start the day of or the day after ICU admission (or transfer).			
	Are you able to capture that VTE prophylaxis was administered?		See general CQM audit guidance above.
	Are you able to capture the time that VTE prophylaxis was administered?		See general CQM audit guidance above.
	What are your acceptable reasons that no VTE prophylaxis was administered in the ICU?		See general CQM audit guidance above.
	Are you able to document the reason for no VTE administration?		See general CQM audit guidance above.
	Are you able to capture “the day of or the day after ICU admission or transfer in?”		See general CQM audit guidance above.
	Are you able to capture patients with an ICU length of stay greater than one day?		See general CQM audit guidance above.
	Are you able to reset the clock for patients who have a surgery on the day of or the day after ICU admission?		See general CQM audit guidance above.

Eligible Hospitals: Pre-Attestation and Audit Checklist Tool

Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #11 VTE 2 - NQF 0372: Venous Thromboembolism – Intensive Care Unit VTE prophylaxis			
	<p>Does your sniff test indicate you are capturing the following exclusions:</p> <ul style="list-style-type: none"> a. Age < 18 b. Length of stay < 2 days c. Length of stay >120 days d. Comfort measures only documented on day of or day after hospital arrival e. Enrolled in clinical trial f. ICU LOS < one day without VTE prophylaxis administered and without documentation for no VTE prophylaxis g. Patients with principal diagnosis of obstetrics h. Patients with principal diagnosis of VTE 		See general CQM audit guidance above.

Eligible Hospitals: Pre-Attestation and Audit Checklist Tool

Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #12 - VTE-3 - NQF 0373: Venous Thromboembolism – Anticoagulation Overlap Therapy			
<p>This measure assesses the number of patients diagnosed with confirmed VTE who received an overlap of parenteral (intravenous [IV] or subcutaneous [subcu]) anticoagulation and warfarin therapy. For patients who received less than five days of overlap therapy, they must be discharged on both medications. Overlap therapy must be administered for at least five days with an international normalized ratio (INR) = 2 prior to discontinuation of the parenteral anticoagulation therapy or the patient must be discharged on both medications.</p>			
	<p>Are you requiring all of your patients with confirmed VTE to have an overlap of at least five days of parenteral anti-coagulation and warfarin therapy regardless of their INR?</p>		<p>See general CQM audit guidance above.</p>
	<p>What information do you accept as confirming a VTE?</p>		<p>See general CQM audit guidance above.</p>
	<p>Are you able to document continued parenteral therapy after discharge if it is required?</p>		<p>See general CQM audit guidance above.</p>
	<p>Does your sniff test indicate you are capturing the following exclusions:</p> <ul style="list-style-type: none"> a. Age < 18 b. Length of stay >120 days c. Comfort measures only documented d. Enrolled in clinical trial e. Without warfarin therapy during hospitalization f. Without warfarin prescribed at discharge g. Without VTE confirmed by diagnostic testing 		<p>See general CQM audit guidance above.</p>

Eligible Hospitals: Pre-Attestation and Audit Checklist Tool

Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #13 - VTE-4 - NQF 0374: Venous Thromboembolism Patients Unfractionated Heparin (UFH) Dosages/Platelet Count Monitoring by Protocol (or Nomogram) Receiving Unfractionated Heparin (UFH) with Dosages/ Platelet Count Monitored by Protocol (or Nomogram)			
This measure assesses the number of patients diagnosed with confirmed VTE who received intravenous (IV) UFH therapy dosages AND had their platelet counts monitored using defined parameters such as a nomogram or protocol.			
			See general CQM audit guidance above.
			See general CQM audit guidance above.
			See general CQM audit guidance above.
			See general CQM audit guidance above.
			See general CQM audit guidance above.
			See general CQM audit guidance above.
			See general CQM audit guidance above.
			See general CQM audit guidance above.
			See general CQM audit guidance above.

Eligible Hospitals: Pre-Attestation and Audit Checklist Tool

Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #14 - VTE-5 - NQF 0375: Venous Thromboembolism - VTE Discharge Instructions			
This measure assesses the number of patients diagnosed with confirmed VTE that are discharged to home, to home with home health, or home hospice on warfarin with written discharge instructions that address all four criteria: compliance issues, dietary advice, follow-up monitoring, and information about the potential for adverse drug reactions / interactions.			
	Are you able to capture that VTE patients discharged on warfarin have received written discharge instructions addressing specific criteria?		See general CQM audit guidance above.
	What information do you accept as confirming a VTE?		See general CQM audit guidance above.
	Are you able to identify patients that are discharged on warfarin therapy?		See general CQM audit guidance above.
	Do you capture each of the following discharge locations: Home Home with home health Home hospice		See general CQM audit guidance above.
	Are you able to document the patients received discharge instructions?		See general CQM audit guidance above.
	Do these instructions include the following criteria: Compliance issues Dietary advice Follow-up monitoring		See general CQM audit guidance above.

Eligible Hospitals: Pre-Attestation and Audit Checklist Tool

Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #14 - VTE-5 - NQF 0375: Venous Thromboembolism - VTE Discharge Instructions			
	Does your sniff test indicate you are capturing the following exclusions: <ul style="list-style-type: none"> a. Age < 18 b. Length of stay >120 days c. Enrolled in Clinical Trial d. Without warfarin prescribed at discharge e. Without VTE confirmed by diagnostic testing 		See general CQM audit guidance above.

Eligible Hospitals: Pre-Attestation and Audit Checklist Tool

Topic/Item	Additional detail	Item addressed	Audit Guidance
CQM #15 - VTE-6, NQF 0376: Venous Thromboembolism – Incidence Of Potentially Preventable VTE			
This measure assesses the number of patients diagnosed with confirmed VTE during hospitalization (not present on arrival) who did not receive VTE prophylaxis between hospital admission and the day before the VTE diagnostic testing order date.			
	Do you identify patients that did not have a VTE on hospital admission?		See general CQM audit guidance above.
	What information do you accept as confirming a VTE on admission?		See general CQM audit guidance above.
	What diagnostic tests do you accept as a test to confirm a VTE?		See general CQM audit guidance above.
	Are you able to capture the time of the test being ordered?		See general CQM audit guidance above.
	How do you determine if the test was used to determine the presence of VTE on arrival or occurring in the hospital		See general CQM audit guidance above.
	Are you able to capture the time that VTE prophylaxis was administered?		See general CQM audit guidance above.

For further information: http://www.cms.gov/EHRIncentivePrograms/32_Attestation.asp