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Governor

STATE OF NEVADA  
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
DIVISION OF HEALTH CARE FINANCING AND POLICY  
1100 E. William Street, Suite 101  
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RICHARD WHITLEY, MS  
Director

MARTA JENSEN  
Acting Administrator

November 25, 2015

Dear Provider:

In order for us to complete our pre-payment review of your Meaningful Use (MU) attestation, we need some supporting documentation from you. Below is a list of the requested documentation. Please upload these documents into your EHR provider portal. Upon receipt of the requested documentation, we will complete our review as quickly as possible. We have attached a Provider Document Checklist for easy reference. If you need assistance, please contact our EHR Help Desk at 888 639-3452.

1. **Patient Volume (Excel file):**

List of *all* Patient Encounters, sorted by Insurance Payer for the 90-day Patient Volume Reporting Period. This report also includes patients without insurance.

***5 Fields required are:***

- 1) Patient ID, *and*
- 2) date of visit, *and*
- 3) location (if more than one), *and*
- 4) provider, *and*
- 5) insurance payer

Insurance payers included in the Medicaid numerator *must be specified*.

2. **EHR System:**

- a) ONC CHPL Product number (available from your EHR vendor or from the ONC CHPL website <http://oncchpl.force.com/ehrcert?q=chpl>), *and*
- b) Copy of your screenprint showing EHR software and version with practice name, *and*
- c) EHR vendor Invoice, *and*
- d) EHR vendor Contract or Lease Agreement.
- e) If you have freeware, please provide a letter of validation from the EHR vendor in lieu of the above.

3. **Pediatricians:** Submit a copy of Pediatrician certification from American Board of Pediatrics (ABP) or from American Osteopathic Board of Pediatrics (AOBP).

4. **Groups:**

List of all Group Providers with titles, date of employment and locations (if more than one).

5. **FQHC, RHC and IHP:**

- a) List of all Providers with titles, date of employment, and locations, *and*
- b) a copy of each provider's employment contract.
- c) PA-led facility letter

6. **Meaningful Use Dashboard Report** – 90 Day Attestation (1-page summary of Core & Menu Measures results)

7. **Screenprints of the following:**

- a. EHR software & Version No. for each practice location
- b. Drug-Drug or Drug-Allergy Interaction check for 1 patient

8. Explanation for each Exclusion declared

## MU Documentation (cont'd.)

9. Test results of Public Health data transmission OR exclusion letter from the registry confirming your declaration of intent to transmit
10. Security Risk Analysis Report (signed and dated)

***Note: The DHCFP is a covered entity as defined in the Health Insurance Portability and Accountability Act (HIPAA) of 1996. Accordingly, the DHCFP complies with the HIPAA Privacy and Security regulations promulgated in 45 CFR 160, 162 and 164. Providers can furnish protected health information about Medicaid or Nevada Check Up recipients without requiring the individual's authorization in accordance with 45 CFR 164.506, when requested by the DHCFP for treatment, payment or health care operations. In addition, providers may furnish protected health information as required by CMS for purposes of the EHR Incentive Payment Plan. All protected health information must be submitted electronically to DHCFP via the online patient portal or via secure message.***

***As a reminder,*** all providers are subject to selection for an on-site audit. Please be sure to retain all records to support the numbers in your attestation for a period of 6 years. Failure to provide sufficient support of attestation information could result in forfeiture of the incentive payment.

Thank you for your assistance.

Sincerely,

EHR Unit - Division of Health Care Financing and Policy  
1000 East William St, Suite 102  
Carson City, NV 89701  
Phone (775) 684-7574  
Fax (775) 684-3772

# DOCUMENT CHECKLIST

## Meaningful Use (MU)

### **Individual Providers:**

\_\_\_\_\_ Patient Volume Encounter report  
(For a detailed description, please see the Patient Volume letter to providers)

\_\_\_\_\_ Pediatrician license and Board certification

\_\_\_\_\_ EHR software & version no. – Provider’s screenprint

\_\_\_\_\_ ONC-CHPL Product Number

\_\_\_\_\_ EHR system invoice – most recent upgrade

\_\_\_\_\_ EHR system contract/user agreement, **OR:**  
Freeware validation letter (in lieu of invoice & contract)

\_\_\_\_\_ MU Dashboard Summary – Core Measures

\_\_\_\_\_ MU Dashboard Summary – Menu Measures

\_\_\_\_\_ Provider explanation for all exclusions

\_\_\_\_\_ Letter from WebIz/Public Health re declaration of intent to transmit **OR:**  
test results of transmission

\_\_\_\_\_ Security Risk Analysis report (signed & dated)

\_\_\_\_\_ Drug-Drug and Drug-Allergy Interaction – Provider’s screenprint

### **Groups:**

\_\_\_\_\_ List of all providers (name, title, DOE, locations)

### **FQHC, RHC, IHP:**

\_\_\_\_\_ List of all providers (name, title, DOE, locations)

\_\_\_\_\_ Provider contracts

\_\_\_\_\_ PA-led facility letter