JEFFREY A. DAVISSON, O.D.
GREENE COUNTY

AGREED UPON PROCEDURES

FOR THE YEAR ENDED DECEMBER 31, 2013

Dave Yost · Auditor of State

Independent Accountant's Report on Applying Agreed-Upon Procedures

Ohio Department of Medicaid
50 West Town Street, Suite 400
Columbus, Oho 43215

We have performed the procedures enumerated below, which were agreed to by the Ohio Department of Medicaid (ODM), on Jeffrey A. Davisson's (hereafter referred to as the Provider) compliance with the requirements of the Medicaid Provider Incentive Program (MPIP) for the year ending December 31, 2013 (program year 2: meaningful use stage 1, year 1). The Provider is responsible for compliance with the MPIP requirements. The sufficiency of these procedures is solely the responsibility of ODM. Consequently, we make no representation regarding the sufficiency of the procedures enumerated below either for the purpose for which this report has been requested or for any other purpose.

1. We reviewed the MPIP system and determined that the provider had met the ODM's pre-payment approval requirements, was approved for incentive payment by ODM and received an incentive payment.

   We compared the date of pre-payment approval with date of incentive payment and determined that the pre-approval occurred prior to payment. In addition, we compared the payment amount with the MPIP payment schedule and determined that ODM issued the correct payment amount in 2013.

2. We reviewed information contained in the Ohio e-license center and verified the Provider's type and license to practice in Ohio during the attestation period.

   We searched the Provider's information as contained in the Medicaid Information Technology System (MITS) and determined that the Provider had an active Ohio Medicaid Agreement during the attestation periods for patient volume and meaningful use.

3. We obtained the list of all patient encounters (separated by payer source) during the attestation period from the Provider. We scanned the list for any duplicate names. We selected five encounters with non-Medicaid recipients from the Provider's Daily Schedule report and traced the encounter to the electronic health record system to match the appointment data.

   We found no duplicates and no unreported encounters.

4. We obtained unique Medicaid encounters from the Quality Decision Support System (QDSS) for the attestation period and compared this to both the Medicaid encounters reported by the Provider in the MPIP system and the Medicaid encounters provided in procedure 3 above.

   We found the variance between these reported numbers was less than 20 percent. We determined that the reported volume in the MPIP system should be used in calculation of the Provider's Medicaid patient volume (see procedure 5).

5. We calculated the Provider's Medicaid patient volume using data from procedures 3 and 4 above.

   The Provider met the 30 percent patient volume requirement.

6. We found that the practice where the Provider had worked was now using a newer version of the same electronic health record (EHR) software reported in the MPIP system. The new version of the software was able to produce reports showing the Provider's use of electronic health records in 2013.We verified that this newer version of the software was approved by the Office of the National Coordinator of Health IT.

7. We obtained a report listing of all of the Provider's patients recorded in the EHR system during the attestation period, and compared this number to the number of all patients seen during the attestation period, which we obtained from the Daily Schedule report, to verify that 80 percent of all unique patients were in the EHR system.

   We found the Provider met the required 80 percent threshold.

8. ODM requested that we determine if Provider had multiple locations and, if so, to perform additional procedures.

   We did not perform this procedure as the Provider did not report multiple locations.

9. We compared supporting documentation obtained from the Provider for the attestation period with the requirements of the 13 core measures and determined if the measure or exclusion criterion was met. For those measures that require only unique patients be counted, we scanned detailed data for each query, and removed any duplicate patients and re-calculated the measure. See conclusion below.

10. Using the five meaningful use menu measures attested to by the Provider in the MPIP system, we determined that one of the public health objectives was selected. We compared supporting documentation obtained from the Provider for the attestation period with the requirements of each menu measures and determined if each measure or exclusion criterion was met. See Conclusion below.

    There was one meaningful use menu measure (008) that is based on percentage of unique patients. The EP was unable to provide detailed query for the report that was generated in 2013 showing that this measure was met. As a result, we were unable to verify that the measure included only unique patients.

11. We obtained the clinical quality measures (core, alternate and additional) attested to by the Provider in the MPIP system. We determined if the Provider reported on the three core and additional clinical quality measures. For any core measurer reported at zero, we verified that an alternate measure was reported. We compared supporting documentation obtained from the Provider for the attestation period with the criteria required for the identified measures and determined if the measures or exclusion criteria was met. For those measures that require only unique patients be counted, we scanned detailed data for each query, and removed any duplicate patients and re-calculated the measure.

    We found that the Provider met the Meaningful Use Core Measures; met the five Meaningful Use Menu Measures and met eight Clinical Quality Measures.

    We also noted the following discrepancies in reported data; however, these issues did not change the overall results reported above:

    - For six of the core measures, we found that the numerator, denominator and/or the percentage reported in the MPIP system did not match the supporting documentation. In all six instances, the result for the measure did not change. We found one core measure (MUCP013) reported as exclusion but supporting documentation showed that it was passed.

- We found results were incorrectly reported under menu measure 009 instead of the correct measure of 010 and the 009 measure should have reflected that the Provider was excluded from this measure.
- We also found discrepancies in numerators and denominators reported for Core Clinical Quality Measure of 0421.

This agreed-upon procedures engagement was conducted in accordance with the American Institute of Certified Public Accountants' attestation standards. We were not engaged to and did not conduct an examination or review, the objective of which would be the expression of an opinion or conclusion, respectively, on the Provider's compliance with the requirements of the Medicaid Provider Incentive Program. Accordingly, we do not express such an opinion or conclusion. Had we performed additional procedures, other matters might have come to our attention that would have been reported.

This report is intended solely for the information and use of the Ohio Department of Medicaid, and is not intended to be, and should not be used by anyone other than the specified party.

Dave Yost
Auditor of State

February 21, 2017

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JEFFREY DAVISSON

GREENE COUNTY

CLERK'S CERTIFICATION
This is a true and correct copy of the report which is required to be filed in the Office of the Auditor of State pursuant to Section 117.26, Revised Code, and which is filed in Columbus, Ohio.

Susan Babbitt

CLERK OF THE BUREAU

CERTIFIED
MARCH 14, 2017

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