VENUS WITTENAUER, D.O.
COLUMBIANA COUNTY
AGREED UPON PROCEDURES

FOR THE YEAR ENDED DECEMBER 31, 2013

Dave Yost · Auditor of State

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Independent Accountants' Report on Applying Agreed-Upon Procedures

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

RE: Venus Stella Olympia Wittenauer, D.O. NPI: 1750375630
Program Year 3: Meaningful Use Stage 1 Year 2

We have performed the procedures enumerated below, which were agreed to by the Ohio Department of Medicaid (ODM), on Dr. Venus Stella Olympia Wittenauer's (hereafter referred to as the Provider) compliance with the requirements of the Medicaid Provider Incentive Program (MPIP) for the year ended December 31, 2013. 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 met the ODM's pre-payment approval requirements, was approved for incentive payment and received an incentive payment.

   We compared the date of pre-payment approval with date of incentive payment and determined that 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.

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 patient volume and meaningful use attestation periods.

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

3. We obtained a manual daily log of all encounters during the patient volume attestation period from the Provider. We scanned the list for any duplicate encounters.

   We found no duplicates.

   ODM asked that we select five patient encounters of non-Medicaid recipients from the Provider's electronic health records (EHR) system and trace the encounters to the Provider's list to identify any unrecorded encounters. We could not perform this procedure as the Provider's EHR system could not produce a patient volume report for the attestation period; therefore, we selected five dates from the daily log reports and totaled encounters for each date and compared these encounters to daily encounter totals in the EHR system.

   We found three encounters in the EHR system that were not reported on the daily logs for the five dates tested.

4. We obtained the Medicaid encounters from the Quality Decision Support System for the patient volume 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 three above.

We found the variance was less than 20 percent and determined that the Provider's Medicaid encounter list 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 location where the Provider 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 EHR software was able to produce reports showing the Provider's use in 2013. We verified that this newer version of this software was approved by the Office of the National Coordinator of Health IT.

7. ODM asked us to obtain a report listing of all of the Provider's patients seen during the meaningful use attestation period and compared this number to the number of all patients recorded in the EHR system to verify that 80 percent of all unique patients were in the EHR system.

   We could not perform the procedure as the Provider could not provide a report totaling the list of unique patients seen during the meaningful use attestation period.

8. ODM requested that we determine if the 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 the MU Summary Report obtained from the Provider for the meaningful use attestation period with the requirements of the 13 core measures and determined if the measure or exclusion criterion was met.

   We found differences, see Meaningful Use Results below.

   ODM asked that for those measures that require only unique patients be counted, we scan detailed data for each query to identify any duplicate patients.

   We did not perform this procedure as the Provider stated they could not provide a report from their EHR system with unique patient data for each applicable core measure.

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

    See Meaningful Use Results below.

    ODM asked that for those measures that require only unique patients be counted, we scan detailed data for each query to identify any duplicate patients.

    We did not perform this procedure as the Provider stated they could not provide a report from their EHR system with unique patient data for the applicable menu measures.

11. We obtained the clinical quality measures (core, alternate and additional) attested to by the Provider.

We determined if the Provider reported on the three core and additional clinical quality measures. For any core measure 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.

See Meaningful Use Results below.

Meaningful Use Results

We found that the Provider met 12 of the 13 Meaningful Use Core Measures; met five Meaningful Use Menu Measures and met nine Clinical Quality Measures.

Responsible Party's Written Representation

The Provider declined to submit a signed representation letter acknowledging responsibility for maintaining records and complying with applicable MPIP regulations; making available all documentation related to compliance; responding fully to our inquiries; reporting any non-compliance subsequent to the end of the engagement period; and disclosing all communications received from regulatory agencies alleging noncompliance with the Ohio MPIP rules.

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 Provider and the Ohio Department of Medicaid, and is not intended to be, and should not be used by anyone other than the specified parties.

Dave Yost
Auditor of State

October 5, 2017

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COLUMBIANA 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
NOVEMBER 9, 2017

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