STEPHEN BUSHEK, M.D.
FRANKLIN COUNTY

AGREED UPON PROCEDURES

FOR THE YEAR ENDED DECEMBER 31, 2014

Dave Yost · Auditor of State

Independent Accountants' Report on Applying Agreed-Upon Procedures

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

RE: Stephen Bushek, M.D. NPI: 1972546455
Program Year 3: Meaningful Use Stage 2 Year 3

We have performed the procedures enumerated below, which were agreed to by the Ohio Department of Medicaid (ODM), on Dr. Stephen Bushek's (hereafter referred to as the Provider) compliance with the requirements of the Medicaid Provider Incentive Program (MPIP) for the year ended December 31, 201x. 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 searched the Medicaid Information Technology System (MITS) and confirmed that the Provider had an active Ohio Medicaid Agreement during the patient volume and meaningful use attestation periods.

2. Using the Ohio e-license center, we confirmed the Provider type was the same as reported in MPIP and confirmed that the Provider was licensed to practice in Ohio during the patient volume and meaningful use attestation periods.

3. We reviewed the MPIP system and determined that the Provider underwent 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 the date of the incentive payment and confirmed that pre-approval occurred prior payment. In addition, we compared the payment amount with the MPIP payment schedule and confirmed that ODM issued the correct payment amount.

4. We obtained the Provider's list of all encounters for an alternate patient volume attestation period (October 1, 2014 to December 31, 2014) as the Provider stated it entered the incorrect original patient volume period (January 1, 2013 to March 31, 2013) in the MPIP system. We scanned the list and found no duplicate encounters.

   ODM also asked us to verify that all payers were included in the encounter list to identify any unrecorded encounters; however, the Provider confirmed with its vendor that the software system could not generate a report showing payer sources. We selected 10 patients from the Medicaid encounter report and traced them to individual screenshots provided by the Provider and confirmed multiple payer sources were included in the encounter list.

5. We compared the Medicaid encounters from the Quality Decision Support System (QDSS) for the alternative patient volume attestation period to the final Provider's Medicaid encounters identified in procedure 4 to confirm if the Provider's encounters exceeded 20 percent of QDSS. We found no variances exceeding 20 percent and we recalculated patient volume using the Provider's Medicaid encounter list and the Provider met the 30 percent patient volume requirement.

6. We found that the Provider's electronic health record (EHR) system was different than the system reported in MPIP. We obtained the end-user agreement to confirm the EHR system selected by the Provider. We verified that the new EHR system was approved by the Office of the National Coordinator of Health IT.

7. We confirmed the Provider's meaningful use reports listed encounters from one location and that location was listed in MITS.

8. We obtained supporting documentation for the core measures and compared it to the applicable criteria. For those measures that require only unique patients be counted, we scanned the detailed data and found no duplicate patients. We found no exceptions.

9. We obtained supporting documentation for the menu measures and compared it to the applicable criteria and confirmed if the minimum number of measures was met, including at least one public health menu measure. For those measures that require only unique patients be counted, we scanned the detailed data and found no duplicate patients. We found no exceptions.

10. We obtained supporting documentation for the clinical quality measures and compared it to the applicable criteria and confirmed the minimum number of measures was met with at least nine measures from three different domains.

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 ODM, and is not intended to be, and should not be used by anyone other than the specified parties.

Dave Yost
Auditor of State

November 7, 2018

Dave Yost • Auditor of State

STEPHEN BUSHEK

FRANKLIN 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
DECEMBER 20, 2018

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