



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: Paul J. Pawlosky, D.O. NPI: 1508842600  
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. Paul J. Pawlosky'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 by ODM and received an incentive payment.

We compared the date of pre-payment approval with the date of the 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 both the patient volume and meaningful use attestation periods.

We also 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 patient volume and meaningful use attestation periods.

3. We obtained the list of all group encounters during the patient volume attestation period from the Provider. We scanned the list for any duplicate patient encounters. We also verified that all payers were included in the encounter list to identify any unrecorded encounters.

We removed duplicate encounters which resulted in revised group encounters of 1,390. We found no unrecorded encounters.

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

We found variances exceeding 20 percent and we determined the group Medicaid encounters reported in the QDSS system was more accurate and 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 of EHR in 2013. We verified that the 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 meaningful use attestation period and compared this number to the number of all patients seen during the same attestation period 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 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 no differences. See Meaningful Use Results below.

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

We could not perform this procedure as the Provider either did not provide unique patient data for each applicable core measure or did not provide a complete list of unique patients as the number of patients did not match the MU summary report.

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

We found no differences. See Meaningful Use Results below.

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

We could not perform this procedure as the Provider did not provide unique patient data for the one measure that required unique patients to be counted.

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 meaningful use 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 the 13 Meaningful Use Core Measures; met the five Meaningful Use Menu Measures and met the six Clinical Quality Measures.

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

May 13, 2017

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PAUL PAWLOSKY

MONTGOMERY 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  
JULY 11, 2017