UCHENNA A. EZIKE, M.D.
RICHLAND 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: Uchenna A. Ezike, M.D. NPI: 1073630893
Program Year 2: Meaningful Use Stage 1 Year 1

We have performed the procedures enumerated below, which were agreed to by the Ohio Department of Medicaid (ODM), on Dr. Uchenna A. Ezike's (hereafter referred to as the Provider) compliance with the requirements of the Medicaid Provider Incentive Program (MPIP) for the year ended December 31, 2014. 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 confirmed that the Provider underwent ODM's pre-payment approval process, 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-payment approval occurred prior to 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 list of all encounters during the original patient volume attestation period (October 1, 2013 to December 31, 2013) from the Provider. We scanned the list and found no duplicate encounters. We also confirmed that all payer sources were included in the encounter list and found no unrecorded encounters.

   We found the Provider did not meet the 30 percent patient volume requirement (see procedure 5). The Provider selected an alternative patient volume attestation period (March 1, 2014 to May 31, 2014). We performed the same duplicate scan and found no duplicates encounters. We confirmed that all payers were included in the encounter list and found no unrecorded encounters.

5. We compared the Medicaid encounters in the MPIP system with those from the Quality Decision Support System (QDSS) and the final Provider's encounters identified in procedure 4 to confirm if the MPIP data exceeded these two reports by 20 percent. We found variances exceeding 20 percent and recalculated the Medicaid patient volume using the Provider's Medicaid encounter list from the original patient volume period. The Provider did not meet the 30 percent patient volume requirement.

We then compared the encounters from the alternative patient volume attestation period to a new QDSS report for the same period. We found variances exceeding 20 percent and we recalculated the Medicaid patient volume using the Provider's Medicaid encounter list. The Provider then 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 electronic health record (EHR) software reported in the MPIP system. The newer version of the software was able to produce reports showing the Provider's use in 2014. We confirmed that the newer version of the EHR software was approved by the Office of the National Coordinator of Health IT.

7. We found that the Provider, nor its software vendor, were able to produce a meaningful use summary report with numerator and denominator patient information. As a result, the Provider could not demonstrate that over 50 percent of total encounters were included and occurred at the one location with the CEHRT installed. We did note the one location the Provider reported in the MPIP system was listed in MITS.

8. We obtained supporting documentation for the core measures and compared it to the applicable criteria. The Provider did not meet 12 of the core measures as the meaningful use summary report did not provide any numerator or denominator patient information to show it met the percentage of unique patients required for 10 of the core measures and we received additional supporting documentation for only one of the remaining three core measures. We could not perform a scan of the detailed data for those measures that require only unique patients be counted, and remove any duplicates, as the Provider could not provide unique patient data for each applicable core measure.

9. We obtained supporting documentation for the menu measures and compared it to the applicable criteria and we confirmed if the minimum number of measures was met, including at least one public health menu measure. The Provider did not meet three menu measures as the meaningful use summary report did not provide any numerator or denominator patient information to show it met the percentage of unique patients required. We could not perform a scan of the detailed data for those measures that require only unique patients be counted, and remove any duplicates, as the Provider could not provide unique patient data for the applicable menu measures.

10. We obtained supporting documentation for the clinical quality measures and compared it to the applicable criteria and we confirmed if the minimum number of measures was met with at least one measure from three different domains. The Provider did not meet the nine clinical quality measures as the supporting documentation did not show it was applicable to the attestation period.

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

Dave Yost
Auditor of State

April 30, 2018

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UCHENNA EZIKE

RICHLAND 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
JUNE 5, 2018

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