JASON A. RUPEKA, D.O.
TRUMBULL COUNTY
AGREED UPON PROCEDURES

FOR THE YEAR ENDED DECEMBER 31, 2013

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: Jason Alexander Rupeka, D.O. NPI: 1942361928
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. Jason A. Rupeka'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 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 the patient volume and meaningful use attestation periods.

   We 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. ODM asked that we obtain a list of all encounters during the patient volume attestation period from the Provider. ODM also asked that we scan the list for any duplicate encounters and verify that all payers were included in the encounter list to identify any unrecorded encounters.

   We were unable to perform this procedure as the Provider did not provide supporting documentation for the encounters during the patient volume attestation period.

4. ODM asked that we obtain the Medicaid encounters from the Quality Decision Support System (QDSS) 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 3 above.

   We compared the encounters from the QDSS to the Medicaid encounters reported in the MPIP system and the variance exceeded 20 percent. We could not compare the encounters from the QDSS to the Provider's Medicaid encounter list, see procedure 3 above; therefore, we could not determine the number of Medicaid encounters which should be used in calculation of the Provider's Medicaid patient volume (see procedure 5).

5. ODM asked that we calculate the Provider's Medicaid patient volume using data from procedures 3 and 4 above.

   We were unable to perform this procedure, see procedure 3 above.

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. We verified that the newer version of the software was approved by the Office of the National Coordinator of Health IT.

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

   We were unable to perform this procedure as the Provider did not provide supporting documentation.

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. ODM asked us to compare supporting documentation obtained from the Provider for the meaningful use attestation period with the requirements of the 13 core measures, the five meaningful use measures (including verifying that at least one of the public health objective was selected), and the three core clinical and additional quality measures attested to by the Provider.

   We were unable to perform this procedure, see Meaningful use Results below.

Meaningful Use Results

We were unable to determine if the Provider met any of the Meaningful Use Core Measures, Meaningful Use Menu Measures or Clinical Quality Measures as the Provider did not provide any supporting documentation.

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

Dave Yost
Auditor of State

October 16, 2017

Dave Yost • Auditor of State

JASON RUPEKA

TRUMBULL 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

88 East Broad Street, Fourth Floor, Columbus, Ohio 43215-3506
Phone: 614-466-4514 or 800-282-0370 Fax: 614-466-4490
www.ohioauditor.gov