CMS Manual System

Pub. 100-06 Medicare Financial Management

Department of Health & Human Services (DHHS)
Centers for Medicare & Medicaid Services (CMS)

Transmittal 60 **Date: NOVEMBER 26, 2004**

CHANGE REQUEST 3492

SUBJECT: Revised instructions on contractor procedures for provider audit and the Provider Statistical & Reimbursement Report (PSRR).

I. SUMMARY OF CHANGES: This transmittal revises and updates language found in previously issued instructions. This revision incorporates changes to the instructions aimed at improving the Medicare contractor's operation in the areas of audit and cost report settlement.

NEW/REVISED MATERIAL - EFFECTIVE DATE*: October 1, 2004
IMPLEMENTATION DATE: January 24, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply to the red italicized material only. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (*N/A if manual not updated.*)
(R = REVISED, N = NEW, D = DELETED) – (*Only One Per Row.*)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	8/Table of Contents
R	8/10/4/Submission of Cost Report Data To CMS
R	8/20/3/Desk Review Exceptions Resolution Process
R	8/30/1/Definition of Field Audits
R	8/30/2/Purpose of Field Audits
R	8/50/1/Establishing the Objective/Scope of the Field Audit
R	8/60/1/Audit Confirmation Letter (a.k.a. Engagement Letter)
R	8/60/2/Entrance Conference
R	8/60/3/Tests of Internal Control
R	8/60/6/Designing Tests/Sampling
R	8/60/10/Pre-Exit Conference
R	8/60/11/Finalization of Audit Adjustments
R	8/60/12/Exit Conference
R	8/70/5/Medicare Cost Report and All Related Documents
R	8/80/1/Qualifications
R	8/80/4/Internal Quality Control
R	8/90/Final Settlement of the Cost Report

Attachment - Business Requirements

Pub. 100-06	Transmittal: 60	Date: November 26, 2004	Change Request: 3492

SUBJECT: Revised instructions on contractor procedures for provider audit and the Provider Statistical & Reimbursement Report (PSRR).

I. GENERAL INFORMATION

A. Background: This revision incorporates changes to the instructions aimed at improving the Medicare contractor's operation in the areas of audit and cost report settlement.

B. Policy: Legal authority for the CMS' audit instructions is found in Medicare regulations published at 42 CFR 413.20, 42 CFR 413.24 and 42 CFR 421.100 (c).

C. Provider Education: No education of the provider is required; these instructions are for the intermediary audit operations only.

II. BUSINESS REQUIREMENTS

"Shall" denotes a mandatory requirement
"Should" denotes an optional requirement

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
Chapter 8										
3492.1	The contractor shall submit an extract of the Medicare cost report to CMS within 210 days of the cost report ending date or 60 days after receipt of the cost report, whichever, is later.	X	X							
3492.2	The contractor shall allow the provider 2 weeks to notify the contractor of any concerns with the desk review adjustments.	X	X							
3492.3	The contractor shall schedule the exit conference 8 weeks after receipt of all outstanding documentation from the provider.	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3492.4	The contractor shall allow the provider 2 weeks to notify the contractor of any concerns with adjustments proposed after the pre-exit conference. If there are no extenuating circumstances, the contractor shall have 8 weeks from the date of receipt of all the outstanding documentation from the provider to finalize the audit adjustments.	X	X							
3492.5	The contractor shall maintain the listed documents in its files, as applicable. The contractor shall send all of the listed documents to the provider, where applicable.	X	X							
3492.6	The contractor shall issue a Notice of Program Reimbursement (NPR) within 60 days after the audit adjustments are finalized if an exit conference is waived. When settling a cost report, the contractor shall use a PS&R with a paid through date no earlier than 120 days prior to the issuance of the final audit adjustment report or 120 days prior to the issuance of the NPR if the contractor did not issue an audit adjustment report. However, if the contractor settles the cost report later than 18 months after the end of the provider's fiscal year, the contractor shall use a PS&R with a paid through date that is no earlier than 15 months after the end of the provider's fiscal year.	X	X							
3492.7	The contractor shall maintain a permanent file for providers, where appropriate.	X	X							

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
3492.8	The contractor shall conduct the audit in accordance with the directives in CMS Pub. 100-06, Chapter 8.	X	X							

III. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact:

Contractor Financial reporting requirements have not changed, and are itemized in the "Requirements" section above.

E. Dependencies: N/A

F. Testing Considerations: N/A

IV. SCHEDULE, CONTACTS, AND FUNDING

Effective Date: October 1, 2004 **Implementation Date**: January 24, 2005 **Pre-Implementation Contact(s):** Christina Dobrzycki (410) 786-3389 Thomas Grieves (410) 786-3373 **Post-Implementation Contact(s):** Christina Dobrzycki (410) 786-3389 Thomas Grieves (410) 786-3373	**Medicare Contractors shall implement these instructions within their current operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Financial Management Manual

Chapter 8 – Contractor Procedures for Provider Audits

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(Rev.60, 11-26-04)

10.4 – Submission of Cost Report Data to CMS

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

You are required to submit an extract of the following Medicare cost reports to CMS in accordance with the Healthcare Cost Report Information System (HCRIS) specifications *within 210 days of the cost reporting period ending date or 60 days after receipt of the cost report, whichever is later*.

- CMS Form 2552-96, Hospital Cost Report, for cost reporting periods ending on or after September 30, 1996
- CMS Form 2540-96, Skilled Nursing Facility Cost Report, for cost reporting periods ending on or after September 30, 1996
- CMS Form 1728-94, Home Health Agency Cost Report, for cost reporting periods ending on or after September 30, 1994
- CMS Form 265-94, Renal Dialysis Cost Report, for cost reporting periods ending on or after December 31, 1994
- CMS Form 1984-99, Hospice Cost Report, for cost reporting periods beginning on or after April 1, 1999

This submission must pass all level one electronic cost report edits (see §10.3 of this chapter) and all HCRIS reject edits.

If the cost report is deemed to be “Low Medicare utilization” or “No Medicare utilization”, do not submit a HCRIS extract of the “as submitted” cost report.

20.3 – Desk Review Exceptions Resolution Process

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Where possible, resolve the exceptions or variances during the desk review by utilizing the available information and through inquiry. Document the conclusions reached on these issues in accordance with the standards for documentation required by CMS (see §60.9) and explain in Column 9 of the "Summary of UDR Exceptions" that the issue was resolved during the desk review. Where adjustments are made during the desk review, follow the instructions in §20.2.F of this chapter for completing the "Summary of UDR Exceptions".

If you do not have all the information necessary to make an adjustment but it appears that an adjustment is required, request the information from the provider before making the adjustment. For example, do not prepare an adjustment if the provider claimed bad debts for Medicare deductible and coinsurance sooner than 120 days from the date of the first bill without first obtaining information necessary to establish that the patient is not indigent.

When additional documentation requests are made to providers as part of the desk review process, ensure that the requests do not violate the provisions of the Paperwork Reduction Act (PRA) of 1980. Requests for additional documentation in connection with desk reviews are generally not subject to PRA requirements if you adhere to the following procedures:

- A specific request for documentation must be made to only one entity, (i.e., the provider whose cost report is under review), and

- Questions must be specific to that provider's particular cost report.

Be considerate of the amount of information you request. If there are several issues in question and the request is for volumes of information, consider conducting a field audit as opposed to resolving the issues through the desk review. If you do request certain information/documentation necessary to resolve a desk review exception(s), inform the provider to furnish this information/documentation within 3 weeks of the date of your request. If the provider does not furnish the documentation within that time-period, either make an adjustment or consider scoping the issue for a field audit.

If you make adjustments during the desk review exceptions resolution process, send them to the provider and request that the provider notify you in writing, within *2 weeks*, of any concerns with these adjustments. Also, inform the provider in writing that these adjustments will become final after you make any necessary modification based on the written concerns and documentation supporting them.

NOTE: See §60.13 of this chapter for supervisory review responsibilities pertaining to the desk review process.

30.1 – Definition of Field Audits

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Providers receiving payments under Parts A and B of Title XVIII of the Act, as amended, are subject to audit of payments applicable to services rendered to Medicare beneficiaries. A field audit is an on-site examination of financial transactions, accounts, and reports as they relate to the Medicare cost report in order to test the provider's compliance with applicable Medicare laws, regulations, manual instructions, and directives.

In performing a Medicare field audit, the contractor should comply with the general, field work, and reporting standards of the Government Auditing Standards (GAS) issued by the Comptroller General of the United States as these standards are applicable to all audits performed by or for any Federal agency. If the contractor engages auditors under a subcontract (see §160 of this chapter) to perform the Medicare audit, the subcontractor's auditors must follow the same GAS and other standards that the contractor is required to follow. However, as specified in §60.*13.C* of this chapter, the contractor cannot delegate the performance of a supervisory review of working papers to a subcontractor. CMS holds the contractor responsible for the subcontract work in the same manner as if its own employees performed the work.

Contractors may limit the scope of a Medicare field audit to a review of selected parts of a provider's cost report and related financial records. In addition, the audit procedures performed on selected areas of the cost report may be limited. Both the selected cost report areas and the related procedures to be applied must be sufficient to meet the audit objectives established from the desk review. When a field audit is being performed and additional audit procedures are required, or additional findings are discovered which may require additional audit procedures, the contractor shall make a prompt evaluation and either approve or disapprove the additional expenditure of audit resources.

The audit culminates in the issuance of an audit report. This report includes an audit adjustment report that presents adjustments to the provider's as-filed costs so that the audited Medicare cost report reflects costs and data in conformity with the Medicare principles of payment.

30.2 – Purpose of Field Audits

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Medicare field audits are conducted in order to: (1) provide reasonable assurance that program payments are based on Medicare reimbursement principles, and *(2)* develop other information that CMS needs to fulfill its responsibilities.

In carrying out your audit responsibilities, your primary goal is to arrive at a correct settlement of the cost report. In so doing, preserve the provider's interest and rights but

at the same time apply program policies to specific situations to assure compliance with these policies. Your authority does not extend to determining whether program policies and procedures are appropriate or should be applied in a given circumstance. Rather, your responsibility is to enforce such policies and procedures. Take corrective action where noncompliance exists.

50.1 – Establishing the Objective/Scope of the Field Audit

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Once you make a decision to perform a field audit on a given cost report by considering the Medicare priorities (see §§40ff of this chapter), use the results of the desk review (see §20.2.F of this chapter), and your empirical knowledge of the provider to define the audit's objectives and the scope and methodology to achieve those objectives. The objectives are what the audit is to accomplish. They identify the audit subjects and performance aspects to be included, as well as the potential finding and reporting elements that the auditors expect. Scope is the boundary of the audit. It addresses such things as the depth of review of the issues/areas selected for audit. The methodology comprises the work in data gathering and in analytical methods auditors will use to achieve the objectives. Auditors should design the methodology to provide sufficient, competent, and relevant evidence to achieve the objectives of the audit. Methodology includes not only the nature of the auditor's procedures, but also their extent (for example, sample size).

The desk review process and your knowledge of the provider help you to determine the issues/areas to be addressed for each audit. (See §20.2.F of this chapter.) If budget limitations or other factors prevent you from including all the exceptions in the scope of the audit for that cost report, rank the exceptions based on their significance. Significance generally relates to the Medicare dollar impact if the provider reports the issue/area incorrectly. This dollar impact should be estimated using appropriate factors (e.g., expense amount, Medicare utilization, number of residents and associated per-FTE-resident amount, number of beds for indirect medical education) that pertain to the computation of the Medicare payment for that exception. If this cannot be accomplished, use the total Medicare dollar payment for the issue/area (e.g., amount of graduate medical education (GME) payment). Significance can also pertain to a present or future risk if the issue is not investigated.

Use this ranking to determine which exceptions can be eliminated from the scope if it is not possible to audit them all. Exclude issues/areas starting from the issue ranked the lowest until you reach the level of audit resources that you can devote to this specific field audit. You must document and support the decision to not audit these issues/areas in your separate desk review working papers. However, if in your *professional* judgment, all the issues/areas are significant, consider adjusting your audit plan (see §40ff of this chapter) by deferring or canceling other audit work (i.e., audits of other providers) of a lesser urgency. If there is no work of lesser urgency, seek guidance from you RO.

Be specific in documenting the issues/areas that you do scope for audit. For example, instead of listing "bad debts" as the area to be audited, specify that you intend to review

the "collection effort" and "120-day rule" only, if this is the case. Draft the audit program as outlined in §50.2 below to determine the extent of review to be performed on each issue scoped for further review.

60.1 – Audit Confirmation Letter (a.k.a. Engagement Letter)

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

The contractor must send the provider an audit confirmation letter for all field audits. This document will improve communications by advising the provider of the items that are to be made available at the entrance conference, as well as the major areas the contractor intends to review during its audit.

The audit confirmation letter should give a minimum of 4 weeks and a maximum of 6 weeks notice of the contractor's intent to make an onsite visit for the purpose of conducting a field audit (see Exhibit II in §170 of this chapter for a sample letter). The engagement letter should be provider-specific and must include the following:

- A list of the required documents that are to be made available by the provider on the first day of the audit.

- Date of the entrance conference. (Enclose the entrance conference agenda – Exhibit III in §170 of this chapter.)

- A request that the provider assign a contact person to be the audit liaison.

- A tentative pre-exit conference date set for the last day of fieldwork. (Enclose the pre-exit conference *format* – Exhibit V in §170 of this chapter.)

- *Notice that an exit conference will be tentatively scheduled during the pre-exit conference to occur within 8 weeks* (or longer if extenuating circumstances arise) after all the outstanding documentation is furnished by the provider.

- Notice to the provider that all documentation and records requested prior to and during the fieldwork time must be given to you in a timely manner and that failure to produce documentation will result in non-negotiable audit adjustments.

- Notice to the provider that, as a general rule, you will not honor any reopening requests for the "lack of documentation" adjustments. This policy has no impact on the normal provider appeal rights with the Provider Reimbursement Review Board.

60.2 – Entrance Conference

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

The entrance conference is an important step in the audit process as it sets the tone for the entire audit. The entrance conference serves to enhance communications between the

contractor and the provider by covering a wide variety of issues. At a minimum, the attendees at the entrance conference should consist of the Medicare auditors who will perform the audit, all appropriate provider personnel (controller, provider liaison, accountants, cost report preparers), and provider consultants (if provider desires).

During the entrance conference, explain the purpose of the field review and stress the need for cooperation especially concerning the release of documentation by the provider. Also, you must inform the provider that if supporting documentation is not received, as a general rule, you will disallow the costs and not reopen the cost report after the notice of program reimbursement (NPR) is issued. Additionally, address the following during the entrance conference.

- Discuss timeframes for conducting the audit *and* schedule the pre-exit conference.

- Discuss the scope of the audit areas to be reviewed, and the fact that the audit may turn up other issues not discussed at the entrance conference;

- Discuss all of the proposed desk review adjustments with the provider;

- Identify the provider's liaison and fully discuss the liaison's role to ensure full cooperation during the audit;

- Discuss administrative issues such as location of working space for the auditors, the hours during which the auditors will have access to this working space, use of copiers, need to make long distance telephone calls, if necessary, and access to fax machines and files; and

- Encourage the third party cost report preparer to be available during the course of the audit and exit conference.

See Exhibit III in §170 of this chapter for a sample of the Entrance Conference agenda.

At the start of the visit (generally after the entrance conference), inventory the provider-prepared documentation noting any items missing from the initial engagement request. Notify the provider in writing of all missing items and request that the items be made available as soon as possible. Follow the same notification policy for any additional documentation that is requested during the audit.

60.3 – Tests of Internal Control

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

A – Provider's Internal Control Structure

A provider's internal control structure consists of the policies and procedures established to provide reasonable assurance that the provider's objectives are achieved. The internal control structure consists of three elements:

- Control Environment: The collective effect of various factors on establishing, enhancing, or mitigating the effectiveness of specific policies and procedures.

- Accounting System: The methods and records established to identify, assemble, analyze, classify, record, and report an entity's transactions and to maintain accountability for the related assets and liabilities.

- Control Procedures: The policies and procedures in addition to the control environment and accounting system that management has established to provide reasonable assurance that specific entity objectives will be achieved.

A provider generally has internal control structure policies and procedures that are not relevant to a particular audit and therefore need not be considered for that audit. For example, policies and procedures concerning the effectiveness, economy, and efficiency of certain management decision-making processes, while important to the provider, do not ordinarily relate to a Medicare audit.

B – Medicare's Policy Regarding Review of Internal Controls

In the Medicare audit environment, a review of and reporting on a provider's system of internal control is generally not warranted or cost effective. The auditor may conclude that it would be inefficient to evaluate the effectiveness of internal control policies and procedures and that the audit can be conducted more efficiently by expanding substantive tests.

You may wish to gain an understanding of the provider's internal control structure when, in your *professional* judgment, this understanding and assessment of the internal controls would significantly affect the scoping of the Medicare audit. This does not mean or require that the internal controls need to be reviewed in every instance. Your understanding can be obtained through sources such as the previous period's completed internal control questionnaire (see Exhibit IV in §170 of this chapter), current year's management letter prepared by the provider's financial auditors (e.g., CPA firm), previous Medicare audit history, and empirical knowledge of the provider.

It is not necessary to test the provider's system of internal control for audits of specifically selected areas such as intern/resident counts or wage index reviews, or for reopenings. Furthermore, where CMS directs you to perform a special audit, CMS may limit, or require no work, in the area of internal control.

If internal controls are not reviewed, the decision should be stated in the scope section of the audit report and documented in the desk review working papers. In this situation, preparation of a report on internal controls (see §70.1 of this chapter) is not required.

C – Obtaining an Understanding of the Internal Control Structure

If you determine that it is necessary to review internal controls in a given situation (e.g., new providers, first audit by the contractor), complete the Internal Control Questionnaire (see Exhibit IV in §170 of this chapter). Since all the aspects of the provider's internal control structure are not relevant to a Medicare audit, this questionnaire is designed to allow you to obtain an understanding of the provider's internal control structure as it applies to Medicare audits. Medicare auditors are concerned with the allowability, reasonableness, classification, and accumulation of cost report data that must be reported in accordance with Medicare principles of payment. Therefore, the Medicare auditor should obtain an understanding of those aspects of the provider's internal control structure that affect the reliability of the cost report data that is being audited within the parameters of the Medicare audit in accordance with CMS' audit instructions. This understanding is ordinarily obtained by:

- Previous experience with the provider;
- Inquiries of appropriate personnel;
- Observation of the provider's activities and operations; and
- Inspection of the provider's documents and records.

Once the information required by the questionnaire has been obtained and in your *professional* judgment you need to test the internal control structure in subsequent years, you may review and update the questionnaire answers and documentation during subsequent audits. Obtain the provider's written concurrence to the answers and documentation as a whole or on a question-by-question basis, as appropriate.

Maintain the internal control questionnaire with all related documentation in a separate section of the permanent file and cross reference to supporting audit working papers, if necessary.

60.6 – Designing Tests/Sampling

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Design such tests as are necessary to accomplish your audit objectives. Your tests must aid you in reaching conclusions necessary to complete the audit. Use sampling when this would be more efficient in testing the universe of transactions, entries, or statistical data within an area of consideration.

Sampling is the application of an audit procedure to less than 100 percent of the items within an account balance, class of transactions, or statistics (e.g., count of interns/residents) to evaluate some characteristic of the such balance, class, or statistics. On the basis of facts known to you, decide if all transactions, balances, or statistics that pertain to the issue/area being tested need to be reviewed in order to obtain sufficient evidence. In most cases, an auditor will test at a level less than 100 percent.

There are two general sampling approaches, nonstatistical and statistical. Either approach, when properly applied, can provide sufficient evidential data related to the design and size of an audit sample, among other factors. A nonstatistical sample may support acceptance of findings, but findings must be scientifically established to support adjustments.

Some degree of uncertainty is inherent in applying audit procedures and is referred to as ultimate risk. Ultimate risk includes uncertainties due both to sampling and other factors. Sampling risk arises from the possibility that when a compliance or a substantive test is restricted to a sample, the auditor's conclusions may be different had the test been applied in the same way to all items in the account balance, class of transactions, or statistics.

If you use a sample to test certain issues scoped for audit, you must include a description of the sampling technique, all parameters used to select the sample, and confidence level in the audit working papers.

A – Planning Samples

Planning an audit involves a strategy for selecting appropriate sample(s). When planning a particular sample, consider:

- The relationship of the sample to the audit objective (e.g., Medicare policies for determining the GME and IME FTE counts of residents differ and these differences must be considered in the decision whether it is feasible to use one sample to test the FTE counts for both purposes);
- Preliminary estimates of materiality levels;
- The allowable risk of incorrect acceptance; and
- Characteristics of the population, i.e., the items comprising the universe.

B – Selecting a Sampling Approach

Because either nonstatistical or statistical sampling can provide sufficient evidence, choose between them after considering their relative cost and effectiveness. Statistical sampling helps to:

- Design an efficient sample;
- Measure the sufficiency of the evidential matter obtained; and
- Evaluate the results.

By using statistical theory, quantify sampling risk in limiting it to an acceptable level. Statistical sampling involves additional costs of designing individual samples to meet the

statistical requirements and selecting items to be examined. Where the audit objective would be best accomplished by stratifying the universe/population into high and low strata (e.g., where Medicare bad debts are being tested), use your judgment in designating the threshold for this stratification. Once determined, review all the items in the high strata population and use statistical or nonstatistical sampling to test the low strata.

C – Sampling Risk

In performing substantive tests of details, consider:

- The risk of incorrect acceptance that the sample supports the conclusion that the items are not materially misstated when they are; and

- The risk of incorrect rejection that the sample supports the conclusion that the items are materially misstated when they are not.

D – Using the Test Results

If the results of testing your sample that was selected using a nonstatistical method indicate probable errors in the universe of transactions, entries, or statistics, document your decision to expand the sample or redesign the sample using a statistical method. If the results of testing your sample that was selected using a statistical method indicate probable errors in the universe, document your decision to project the error to the universe/population.

If your adjustment pertains only to the error(s) that was identified, you must document the reason for not considering the effect of the error(s) on the universe.

60.10 – Pre-Exit Conference

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Conduct a pre-exit conference on the last day that the audit team is conducting the fieldwork. Give the provider a copy of all the tentative audit adjustments and working papers (where requested by the provider) including those being proposed due to lack of documentation and discuss all the tentative adjustments that the provider wishes to go over. Also, give the provider a written list of any outstanding documentation that you requested but have not received to date. Inform the provider to furnish your audit staff with the additional documentation within 4 weeks. Establish an exit conference date that will allow *up to 8* weeks (or longer if you can document extenuating circumstances) for review of any additional documentation that the provider may provide and to resolve any disputes over new audit adjustments proposed after leaving the provider's site.

See Exhibit V in §170 of this chapter for a sample pre-exit conference format.

60.11 – Finalization of Audit Adjustments

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Use the time period between the pre-exit conference and exit conference to review any additional documentation submitted by the provider in response to your request at the pre-exit conference or in support of the proposed audit adjustments that the provider did not agree with. CMS encourages continuing dialogue during this period between you and the provider for issues where agreement was not reached at the pre-exit conference. However, it is not necessary to consider any documentation that is received after the timetable provided at the pre-exit conference unless prior arrangements with the provider have been made.

While you should not refuse to accept documentation submitted after the established timeframes, you do not need to consider it in the initial NPR issuance. If a reopening is later granted (see §100ff of this chapter) or a timely appeal is made, the late documentation may be considered at that time.

At the conclusion of your review of the provider's documentation, prepare an audit adjustment report (see Exhibit VI in §170 of this chapter) and clearly identify all new or modified adjustments that the provider did not see previously by indicating the date of the change. Send this audit adjustment report to the provider with a request to notify you in writing, *within 2 weeks*, of any concerns with the new or modified adjustments. Also, inform the provider in writing that the audit adjustments will become final after you make any necessary modification based on those written concerns and documentation supporting them. Therefore, any documentation submitted later (e.g., at the exit conference) will not be considered for the purpose of issuing the Notice of Amount of Program Reimbursement (NPR).

Unless you can document extenuating circumstances, you have up to 8 weeks from the date that you receive all the outstanding documentation from the provider for the finalization of the audit adjustments. This period includes the "2 weeks" that you must give the provider to review and comment on any audit adjustments not presented at the time of the pre-exit conference.

60.12 – Exit Conference

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Each provider is entitled to an exit conference. *Make the provider aware that if it* wishes to waive a formal exit conference, it must notify *you* of this decision in writing *(e-mail note will suffice) at any time before the scheduled date of the exit conference. (See Exhibit II* in §170 of this chapter.)

Persons attending the exit conference should be those parties authorized to make final decisions with respect to the audit. In addition, CMS encourages third party preparers of the cost report to attend.

At the start of the exit conference, give the provider all the audit adjustments (including those made due to "lack of documentation) that were finalized in a manner described in §60.11 of this chapter. Also, give the provider copies of requested working papers if they were not previously given to the provider. Since the provider had an opportunity to comment on all the audit adjustments during the pre-exit conference and during the finalization period, there should be no need to change them during the exit conference.

If additional documentation is submitted during the exit conference, do not refuse it. Rather, inform the provider that you do not need to consider this documentation in the initial NPR since the documentation was not submitted within the established timeframes (see §§ 60.10 and 60.11 of this chapter). If a reopening is later granted (see §100ff) or a timely appeal is made, the late documentation may be considered at that time.
Also, explain during the exit conference that the provider may still appeal "any lack of documentation" or other issues to the Provider Reimbursement Review Board (PRRB).

The exit conference can be performed telephonically. However, include a written record of the issues discussed (either telephonically or onsite), including the explanation pertaining to the "lack of documentation adjustments", in your working papers.

70.5 – Medicare Cost Report and All Related Documents
(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Maintain the following documents (as applicable) related to the Medicare cost report and Medicare audit report(s) in your files. Also, send all the relevant documents detailed below to the provider at the time you settle (see §90 of this chapter) the cost report.

- Transmittal letter to the provider;
- Letter of overpayment collection or check disbursement;
- Notice of Amount of Program Reimbursement (NPR) – (see PRM-1, §2906 for a sample format);
- Auditor's report(s) for the audit and, if applicable, for internal control structure **or** a form of report where the cost report was settled without audit;
- Listing of areas selected for audit;
- Listing of the applicable internal control policy and procedure categories, as they affect Medicare payment;
- Listing of reportable conditions and material weaknesses (only if reportable conditions or material weaknesses were found);
- Management letter, if applicable;
- Cost report adjustment report; and
- Audited or settled without audit Medicare cost report.

80.1 – Qualifications

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

The first general standard for government auditing is:

"The staff assigned to conduct the audit should collectively possess adequate professional proficiency for the tasks required."

Ensure that the Medicare audit is conducted by staff that collectively has the knowledge and skills necessary for the audit. These qualifications apply to the knowledge and skills of the contractor's organization as a whole, and not necessarily to every individual auditor.

A – Continuing Education and Training (CET)

To meet this standard, the contractor shall establish a program to ensure that its staff maintains professional proficiency through CET.

The following represent the continuing education responsibilities of an audit organization and also reflect additional guidance from CMS to help the contractor meet the requirements imposed by GAS.

B – Education Required

All persons responsible for planning, directing, conducting, reviewing, or reporting on government audits must receive at least 80 hours of continuing education and training (CET) every two years. For example, auditors who first start conducting audits in accordance with GAS on January 1, 2002, must complete the CET requirements as follows:

- The first 80 hours must be completed by December 31, 2003. Any excess over the 80-hour requirement does not carry forward to the next two-year cycle.
- After CET requirements for the first two-year period (i.e., January 1, 2002, to December 31, 2003) have been satisfied, a rolling count is permissible for measuring compliance with the requirements. Under a rolling count, compliance with the CET requirements is measured annually using the two most recent years.
- At least 20 hours must be completed in each year of the two-year cycle.
- At least 24 of the 80 hours must be in subjects directly related to government environment and to government auditing. Since the contractor is operating in a specific or unique environment, i.e., Medicare, it shall schedule the 24 hours of training, noted above, in subjects related to the government environment and to the Medicare auditing process.
- Appropriate courses on Medicare and other health care related issues include, but are not limited to, GAS, Medicare policy development (how it affects audits), preparation and review of Medicare audit working papers, current Medicare audit and

payment issues, and the AICPA Audit and Accounting Guide: Providers of Health Care Services.

For purposes of the 80-hour and the 24-hour requirements, CMS interprets the term "conducting" and the phrase "conducting substantial portions of the field work" as referring to those individuals who perform substantial portions of the tests and procedures necessary to accomplish the audit objectives in accordance with GAS. An individual is considered to be responsible for "conducting substantial portions of the field work," for purposes of the CET requirements, when the following conditions are met:

- On a given audit, the individual performs 20 percent or more of the total field work; or
- In a given year, the individual's chargeable time to government audits is 20 percent or more of the individual's total chargeable time.

Auditors who have been employed by the audit organization for less than one year of a given two-year period are not required to complete a minimum number of CET hours. However, entry-level auditors with less than one year with the audit organization must receive appropriate training during their first year with the audit organization. Auditors employed by the audit organization for one year, but less than two years, in a given two-year period, must complete a minimum of 20 hours of CET in the full calendar year. All auditors to whom the CET requirements for 80 hours and 24 hours apply have two years to meet the requirements.

Terminated employees must have been trained in accordance with the contractor's plan of training, at least until a formal notice of termination is received or issued.

Auditors who have not completed the required number of CET hours for any two-year period for a legitimate reason will have the two months immediately following the two-year period to make up the deficiency. Auditors must make up any deficiency in the 24-hour requirement first. The contractor shall not count any CET hours completed towards a deficiency toward either the 20-hour requirement in the year in which they are taken, or the 80-hour and the 24-hour requirements for the two-year period in which they are taken.

C – Employees Covered Under the CET Requirement

Under GAS, any auditor who is responsible for planning, directing, conducting, reviewing, or reporting on government audits is subject to the CET requirements. Also, anyone whose decisions affect the outcome of government audits is covered by CET requirements. Since the contractor may use various types of employees in the audit process, the following is CMS's interpretation of the applicability of CET requirements to certain types of employees:

- Junior Auditors – CET requirements extend to junior auditors who perform portions of the audit. "Conducting" is not limited to auditors in a supervisory or management role.

- Contract Auditors – Per GAS requirements, when the contractor contracts with CPA firms for entire audits, or to provide audit staff to work under its supervision, they are subject to the same requirements as the contractor. The contractor shall require compliance with the CET requirements as a specific condition of the audit subcontract. It shall obtain written assurance that each person meets CET requirements prior to the start of each audit.

- Temporary Auditing Staff – A temporary auditor who is hired for a very limited timeframe, not to exceed one quarter at a time or in one year, under the contractor's direct supervision, is not subject to CET requirements.

- Crossover Staff – Staff members used in multiple functions must meet the CET requirements when their decisions could affect the outcome of an audit. For CET purposes employees who are transferred to the Medicare audit department are considered new hires, as are employees who are promoted to a professional staff level.

- External Consultants and Internal Consultants and Specialists – External consultants and internal consultants and specialists must be qualified and must maintain their professional proficiency in their area of expertise and specialization, but they are not required to meet the GAS CET requirements. For example, attorneys the contractor employs, who work in the provider appeals area, are not subject to the CET requirements, but they must maintain their professional proficiency.

- Clerical and Paraprofessional Staff – Clerical and paraprofessional staff, including student interns, are not subject to the CET requirements.

Review all position descriptions to ensure that they accurately reflect the employees' duties and responsibilities. If you have concerns or questions on certain position descriptions, submit your questions to your RO for a determination. These position descriptions will be reviewed by CMS and the Office of the Inspector General (OIG) to determine the need for compliance with the CET requirements.

D – Contractor Responsibility

Establish and implement a program to ensure that the auditors meet the CET requirements. You must:

- Prepare a general plan for training. Review and revise the plan, as appropriate, and allocate resources to ensure that all staff subject to CET requirements receive training; and

- Implement the CET program to ensure that for every two-year period the 80-hour and 24-hour requirements are met, and that at least 20 CET hours are completed in each year of the two-year period.

- Retain course information for your employees receiving CET credit for contractor-sponsored courses. Maintain records for a five-year period from the completion of the two-year period. Maintain a record for each employee which reflects:
  - Record of participation;
  - Course agenda;
  - Course date(s);
  - Location at which the course was given;
  - Name(s) of instructor(s) and related training, education, and experience;
  - Number of CET credit hours; and
  - Copy of course material presented.
- Retain course information for employees receiving CET credit for outside courses. Maintain records for a five-year period from the completion of the two-year period. Obtain a letter of completion or certificate, and retain a record for each employee which reflects:
  - Name of course;
  - Course date(s);
  - Location at which the course was given;
  - Course sponsor; and
  - Number of CET credit hours.
- Submit, to the appropriate RO, an annual certification by January 31 following the close of any calendar year, stating that it is complying with the CET requirements.

E – General Guidelines for Training Courses

Chapter Three of GAS, entitled "General Standards", states that continuing education and training may include such topics as current developments in audit methodology, accounting, assessment of internal controls, principles of management and supervision, financial management, statistical sampling, evaluation design, and data analysis. It also

includes subjects related to the auditors' specific field of work. The contractor shall consider the following sources when developing a training program for auditors:

- Recognition for Courses Needed for CPA Licensing – In meeting the overall 80-hour requirement, courses approved or recognized by the AICPA or the respective state licensing board that contribute to the auditors' professional proficiency are recognized for purposes of meeting the CET requirements.
- CMS-Sponsored Training – From time to time, CMS may contract with vendors to provide training courses and will notify you of their availability. In addition, CMS may offer training in settings such as a national audit conference.
- Contractor-Sponsored Training – The contractor *should* obtain sponsorship status for its training courses through its respective state CPA licensing board. This will help to ensure that the courses will meet the CET requirements. Also, the courses will be recognized for CPAs on your staff that is required to obtain continuing professional education credits for CPA licensure. In the development of in-house training, the contractor shall consider the AICPA's Statement of Standards for Formal Group and Formal Self-Study Programs. While in-house training is recognized as the most cost-efficient method of training, the contractor should not rely solely on this method.
- Credit Hours – CET credit may be given for whole hours only, with a minimum of 50 minutes constituting one CET hour. As an example, 100 minutes of continuous instruction counts for two CET hours. However, 50 or more but less than 100 minutes of continuous instruction only count for one CET hour.

A conference in which individual segments may be less than 50 minutes is counted as one program, rather than several short programs. The total minutes of all segments will be divided by 50 minutes in order to determine the CET hours for the program.

For a college or university course, each unit of credit earned on a semester system will equal 15 CET hours. Each unit of credit earned on a quarterly system will equal 10 CET hours.

- Credit for Instructor Preparation Time – When an instructor or discussion leader serves at a program for which participants receive CET credit, and is at a level that increases professional competence, the contractor shall give CET credit for preparation and presentation time measured in terms of credit hours. For the first time a program is presented, CET hours will be received for actual preparation time, up to two times the class hours. For example, if a course is rated as eight CET hours, the instructor should receive up to 24 hours of CET credit (16 hours for preparation and eight hours for class time). For repeated presentations, the instructor should receive no credit unless the subject matter has changed sufficiently to require additional study or research. In addition, the maximum credit for preparation should not exceed 50 percent of the total CET credit an instructor or discussion leader accumulates in a two-year CET reporting period.
- Individual Study Programs – Individual study programs that may receive CET credit include correspondence courses and courses given through audiocassettes,

tapes, videotapes, and computers. (See the AICPA's standards for more detailed requirements.)

F – Staff Qualifications

Qualifications for staff members conducting Medicare audits include:

- A knowledge of the methods and techniques applicable to Medicare auditing, and the education, skills, and experience to apply such knowledge to the audit being conducted;

- A knowledge of the Medicare program;

- Skills to communicate clearly and effectively, both orally and in writing; and

- Skills appropriate for the audit work being conducted.

80.4 – Internal Quality Control

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

The fourth general standard for government auditing is:

"Audit organizations conducting government audits should have an appropriate internal quality control system in place and participate in an external quality control review program."

Establish an internal quality control program and provide reasonable assurance that your Medicare audit department:

- Has established, and is following, adequate audit policies and procedures; and

- Has adopted, and is following, applicable auditing standards.

A – External Quality Control Review (Review of the Internal Quality Control System)

OIG will perform an external review of your internal quality control system. CMS will also review your internal quality review program as part of the Audit Quality Review Program (AQRP) or using other review mechanisms. Any tests of your internal quality control system must evaluate:

- The existence of such a system;

- Compliance with the system; and

- The effectiveness of the system.

B – Establishment of an Internal Quality Control System

Establish internal quality control policies and procedures for your Medicare audit department, i.e., all Medicare audit and payment related activities. Communicate these policies and procedures to Medicare audit personnel. While the objective of internal quality control systems is always the same, the nature and extent of such systems can vary based on a number of factors. Normally, documentation of internal quality control policies and procedures would be expected to be more extensive in a larger contractor than a smaller contractor, and more extensive in a multi-office contractor than in a single-office contractor. Therefore, in developing such a system, consider the following factors:

- The size of its Medicare audit department;

- The degree of operating autonomy allowed to your personnel and audit offices;

- The nature of your work;

- Your organizational structure; and

- The cost effectiveness of an internal quality control system.

C – Elements of Internal Quality Control

In addition to the other elements of GAS and Generally Accepted Auditing Standards (GAAS), consider each of the elements of internal quality control listed below, to the extent applicable to your operating environment, in establishing your internal quality control policies and procedures. The nine elements of internal quality control taken from the AICPA Statements of Quality Control Standards are:

- Independence – To be free from financial, business, family, and other relationships involving the provider when required by the profession's code of conduct.

- Consultation – To have personnel seek assistance, when necessary, from competent authorities, so that accounting or auditing issues are resolved properly.

- Assignment of Personnel to Audits – To have personnel on the job who have the technical training and competence required for the circumstances.

- Supervision – To determine that work is planned and carried out efficiently and in conformity with professional standards.

- Advancement – To have people at all levels of responsibility that are capable of handling the responsibilities involved.

- Hiring – To have competent, properly motivated people of integrity involved in audits.

- Professional Development – To provide staff with the training needed to fulfill their responsibilities and to keep them abreast of current developments.

- Acceptance and Continuance (fraud and abuse) – To anticipate potential problems with providers where fraud or abuse is suspected.

- Inspection – To conduct periodic internal reviews to be sure that the other elements of the internal quality control system are working.

D **– Application of the Elements of Internal Quality Control to the Medicare Environment**

(1) Independence

Establish policies and procedures to provide reasonable assurance that all Medicare audit and reimbursement professional staff maintain their independence so as not to impair, or appear to impair, your independence in carrying out its Medicare audit responsibilities. You must:

- Designate an individual or group to provide guidance and to resolve questions of independence matters.
- Communicate, in writing, the policies and procedures relating to independence to personnel at all levels.
- Obtain the confirmation of independence of firms engaged to perform audits or segments of audits. Obtain a separate representation for each audit.

- Obtain from your personnel periodic, written representations of their independence on an annual basis, stating that:
  - They are familiar with your independence policies and procedures.
  - Financial interests in providers and related entities are not held and were not held during the period. Any such financial interests must be listed, detailing the number of shares or the dollar amounts.
  - Personal, professional, or family relationships with providers and related entities do not exist and did not exist during the period. List any relationships with an explanation, including the names of the parties to the transaction.
  - There were no transactions that might impair the extent of inquiry or disclosure, or affect audit findings in any way. List any transactions with an explanation, including the names of the parties to the transaction.

(2) Consultation

Establish policies and procedures to provide reasonable assurance that staff will seek assistance, to the extent necessary, from persons having the appropriate levels of knowledge, competence, judgment, and authority. You must:

- Maintain technical manuals (e.g., GAS, SAS) and Medicare manuals.
- Issue memoranda or other pertinent material to staff regarding Medicare payment issues.
- Inform staff of procedures to follow in resolving technical problems, including referrals to CMS and industry associations.
- Maintain subject files containing the results of consultations for reference and research purposes.

(3) Assignment of Personnel to Audits

Establish policies and procedures to provide reasonable assurance that persons *who are assigned to perform audits* have the degree of technical training and competence required for the circumstances.

Describe the method used to assign professional personnel to audits, including:

- The basis on which assignments are made;
- How staff are advised of their assignments, whether orally or in writing;
- Who is responsible for making staff assignments on a day-to-day basis; and
- How staff are informed of estimated time requirements and of any special skills or experience that a given assignment may demand.

(4) Supervision

Establish procedures for supervision that are distinct from responsibilities of individuals to adequately plan and supervise the work on a particular audit.

Assure that the policies and procedures for planning, performance, and supervision of audits meet the GAS standards of quality. You must:

- Provide procedures for planning individual audits in accordance with Medicare instructions, such as:
  - The development of proposed audit programs;
  - The determination of staffing requirements and the need for specialized knowledge; and
  - The development of estimates of time required to complete the audit.
- Provide procedures for maintaining standards of quality for work, such as:
  - Guidelines for the form and content of working papers;
  - Procedures for resolving differences of professional judgment among members of an audit team; and
  - Standard forms, checklists, and questionnaires appropriate to assist in the performance of audits.
- Provide procedures for reviewing audit working papers and reports.

(5) Hiring

Prepare staff job descriptions and policies and procedures for hiring to provide reasonable assurance that those employed are able to perform audits competently. It must:

- Plan for staffing needs at all levels;
- Establish quantified hiring objectives based on current workload, anticipated changes in workload, staff turnover, individual advancement and retirement, and current Medicare budget; and
- Establish qualifications and guidelines for evaluating potential hires at each professional level.

(6) Professional Development

Establish policies and procedures for professional development to provide reasonable assurance that staff will have the knowledge required to enable them to fulfill assigned responsibilities and to progress within your Medicare audit department. While GAS requires you to ensure that audit staff acquire a certain minimum of CET, the Professional Development Standard of internal quality control addresses the appropriateness of the professional education to the achievement of audit quality. You must:

- Establish a plan for meeting its CET requirements and communicate it to Medicare audit staff; and

- Provide for on-the-job training, such as varying assignments among audit staff, assigning staff to different supervisors.

(7) Advancement

Establish policies and procedures for advancing staff to provide reasonable assurance that those selected for advancement have the qualifications necessary for fulfillment of the responsibilities assigned. You must:

- Specify qualifications deemed necessary for the various levels of responsibility within its Medicare audit department; and
- Evaluate the performance of personnel and periodically advise staff of their progress. Maintain personnel files containing documentation relating to the evaluation process.

(8) Acceptance and Continuance (Fraud and Abuse)

The usual considerations for acceptance and continuance of clients of CPA firms are not applicable to the Medicare audit environment. Although the nature of the relationship with the audit subject is materially different from that experienced by a CPA firm, there is equivalent concern with a Medicare audit in which fraud and abuse is suspected. Accordingly, make a full and immediate disclosure to your CMS RO and to the OIG, as appropriate, of suspected or detected fraud, abuse, illegal acts, or material misstatements or misrepresentations on the part of any provider, other organization or individual. (See §140ff of this chapter.)

(9) Inspection

Establish policies and procedures for inspection to provide reasonable assurance that the procedures relating to the other elements of internal quality control are being effectively applied. Monitor the effectiveness of inspection policies and procedures. Develop the procedures for inspection and ensure that inspections are performed by individuals acting on behalf of your management. You must:

- Prepare instructions and review programs for use in conducting inspection activities;
- Establish frequency and timing of inspection activities and criteria for selection of engagements; and
- Provide for reporting inspection findings to the appropriate management levels and for monitoring actions taken or planned.

90 – Final Settlement of the Cost Report

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

CMS expects that you settle (i.e., issue a Notice of Amount of Program Reimbursement (NPR)) all cost reports that are not scheduled for audit within 12 months of acceptance of a cost report.

If you audit a cost report, issue the NPR to the provider within 60 days of the exit conference *or within 60 days after the audit adjustments are finalized (using the timeframes described in §60.11 of this chapter) if an exit conference is waived.*

As a general rule, if proper notification was given to the provider (see §§60.1 and 60.2 of this chapter) and adjustments were proposed due to the "lack of documentation" as described in 42 CFR 413.20 and 42 CFR 413.24, issue the NPR without considering documentation received from the provider after the established timeframes unless there are circumstances that you have previously approved.

If the provider used the PS&R settlement data to file the cost report or if you decide to use the PS&R data because the provider's reported settlement data is not documented properly, settle the cost report using a PS&R *with a paid through date* no earlier than *120* days prior to the issuance of the final audit adjustment report. If you do not issue an audit adjustment report (e.g., there were no desk review exceptions resolution process adjustments or field audit adjustments), use a PS&R *with a paid through date that is* no earlier than *120* days prior to the NPR date. *If you settle the cost report later than 18 months after the end of the provider's fiscal year, use a PS&R with a paid through date that is no earlier than 15 months after the end of the provider's fiscal year.*

110 – Audit Responsibility When Provider Changes Contractors

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

If the provider changes contactors, the outgoing contractor is responsible for auditing the last cost report that the provider filed while still being serviced by that contractor. This is based upon the contractual functions to be performed by contractors outlined in Article II, Sections A, B, and C of the Agreement. These sections require the contractor to make determinations of the amounts of payments to be made to providers, to account for funds in making such payments, and to audit their records. This clearly calls for the contractor servicing the provider to account for all transactions that have taken place while the relationship existed. This includes an audit of the provider's records and determination of the final settlement as well as finishing any work related to appeals of cost reports that you were responsible for settling.

If you are the outgoing contractor, *upon its request, forward to the incoming contractor copies of the last as-submitted and settled cost report that you are responsible for and any other requested information/documentation*. This provides cost report information so the incoming contractor can review and, if necessary, adjust the interim rate and perform the subsequent year's audit. If you need any of the working papers to complete the work

on pending appeals that you are responsible for and you did not retain copies of those working papers, request that the incoming contractor send you copies at the time you need them.

If you are the incoming contractor, you should generally audit the first cost report filed by a provider that is new to you as a result of changing contractors unless the provider (e.g., SNF or HHA) is paid entirely under the prospective payment methodology or the amount of Medicare reimbursement is insignificant. This gives you a basis from which to review and evaluate subsequent years' cost reports. The audit of a cost report from a provider that changed contractors is:

- Limited to those issues, if any, pending from prior cost report examinations in the case of the contractor closing its final cost report, or
- Performed to the extent necessary to supplement information received from the prior contractor in the case of the contractor examining the provider's first cost report.

120 – Audits of Home Offices

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Where a provider is related *within the meaning of 42 CFR 413.17 to a chain organization* and services are furnished to the provider by the home office or other organizational entity of the chain, the reasonable costs of the services furnished are includable in the provider's costs for reimbursement. The reasonable costs of home office services are determined under guidelines in the PRM, Part I, §§2150ff. and other sections relating to specific costs.

120.6 – Standards for Issuance of an Audit Report for a Home Office

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

The responsible/designated contractor will issue an audit report if it audits a home office cost statement. While it is appropriate to use the general format of the sample “Form of Report on Audit of Medicare Cost Report” (see Exhibit *VII in §170 of this chapter*) for a home office cost statement, the contractor should modify the language of the audit report to reflect this type of entity. For example, a home office is not a provider of Medicare services receiving direct payment from the Medicare program. Therefore, the reference to payment amounts in the second and fourth paragraphs of the sample audit report is inappropriate under these circumstances. Similarly, the contractor should change references to "cost report" and “provider” to "home office cost statement" and “home office”. Furthermore, the contractor must substitute the following elements in the audit report for home office in place to similar elements related to the cost report.

- If the report relates to a home office cost statement, a statement that GAS standards require the contractor to plan and perform the audit to obtain reasonable assurance about whether the Medicare home office cost statement is prepared in accordance with Medicare laws, regulations, and instructions, and

- A statement that the Medicare home office is responsible for compliance with Medicare laws, regulations, and instructions.

130 – Provider Permanent File

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

The permanent reference files are central files that contain provider information. Where appropriate, maintain a current permanent reference file on each provider with pertinent information for use during interim rate reviews, desk reviews, and field audits.

Obtain the appropriate information you maintain in the permanent reference files through the use of Provider Cost Report Reimbursement Questionnaire (Form CMS-339). This information is necessary for the normal servicing of the provider's organizational set-up and history and constitutes a minimum level of provider knowledge. Update the information to reflect changes in the provider's operations and financial arrangements, or amendments to the law and resulting revisions to the provider reimbursement manuals. It is not necessary to have complete copies of documents, such as partnership agreements, leases, fixed asset plant ledger, unless there is something in the document so peculiar to the provider that it warrants special notice. In lieu of a particular document, the permanent reference files may contain a narration, extracts, summaries and/or examples of pertinent information contained in the document.

The following are examples of the information that should be maintained in the permanent reference file. However, note that some of this information may not be necessary or appropriate for the desk review and audit of certain types of providers (e.g., those reimbursed entirely under the prospective payment system) and may not be required to be submitted with Form CMS-339. Therefore, the only information that you are required to maintain in the permanent reference file is the information that the specific provider is currently required to submit with the Form CMS-339. This, however, should not prevent you from including in the permanent reference file any information you obtain during a field audit and deem appropriate to be retained for future reference.

A – General Information.

(1) Accounting Systems and Records

42 CFR 413.20 requires providers to maintain sufficient financial and statistical data for proper determination of costs payable under Medicare. Standardized accounting, statistics, and reporting practices are followed. In keeping with this requirement, establish and maintain surveillance over the provider's capability to maintain records needed to reflect accurate cost reporting data and other information capable of verification by qualified auditors. Document these determinations and retain them in the permanent files.

(2) Accounting System

Request any significant modifications to the provider's accounting system as updates to the initial system survey performed when the provider entered Medicare. Indicate reliance upon the provider's independent accounting firms' opinions by making reference to them in the permanent reference files.

(3) Provider's Organization

Obtain, or develop with the assistance of the provider, an organizational chart. Update it where there are significant changes during any cost reporting period.

Document information for owners and/or partners of providers to include:

- Title of position(s) held by owner and/or partner of provider.

- The same information for officers and members of the board and their stock ownership, if any.

- Duties and responsibilities of all owners, partners, officers, etc., as appropriate, and individual qualifications related to the duties performed where compensation for them is claimed in the cost report.

- Ownership or interest in other providers participating or not participating in the program.

- Ownership or interest in any other entity doing business with the provider.

- Ownership by a chain organization, where applicable, with the name and address of the home office, description of costs which flow from the parent organization, and the contractor responsible for the home office audit.

- Information for nonprofit organization providers to include:

  - Copy of the Internal Revenue Service certificate of nonprofit status under §501(c) of the Internal Revenue Code; and
  - Documentation to support the legal and operating name of the sponsoring organization(s) or person(s).

- Information for providers requesting multiple-facility status for cost reimbursement purposes includes:

  - Documentation that the provider consists of several component facilities which provide clearly different types of care; and
  - Determination that the provider's records have the capability to separate costs and revenues between the various entities of the facility.

(4) Floor Plan of Provider's Facility

If feasible, retain a copy or pertinent extracts of the facility's floor plan. Update significant changes. Indicate that the floor plan was tested during an audit or during an on-site visit.

(5) Provider's State License and Medicare Tie-In Notice

If you obtain these documents as part of your field audit of the number of beds or excluded unit/subprovider costs, retain them in your permanent file.

B – Contracts for Services

(1) Services Purchased Under Arrangements

Where a provider purchases services, such as housekeeping, physical therapy, prescription drugs, laboratory tests, etc., obtain a listing of all services furnished by outside suppliers.

Where they are performed under contract, document information, the services to be furnished and, where applicable, the charge or fee schedule.

(2) Property-Lease Agreements

- Maintain copies of major lease agreements or extracts for all leased parts of the facility. Include major movable equipment or other assets.

- Determine if the lessor is related and/or if the lease agreement constitutes a lease purchase contract. Where such circumstances exist, apply policies applicable to either related organizations, from PRM-1, Chapter 10 or to lease-purchase agreements, PRM-1, §110B.

(3) Provider-Based Physicians

Obtain a copy of all current written agreements or extracts, or a written summary of oral agreements between the provider and physicians which:

- Identifies each department where they work in the provider;

- Lists each physician furnishing services in each department;

- Describes each physician's professional and provider activities;

- Describes all compensation arrangements;

- Lists any fee schedules utilized; and

- Lists billing methods selected by the physicians with detailed information pertaining to the specific method selected.

- Maintain amendments or new agreements. Maintain copies of contracts or extracts and results of any analyses performed. Have them available for desk review personnel and field auditors.

(4) Management and Consultant Services

Have on file management and consultant agreements to identify the services furnished in sufficient detail to determine if these services are necessary and proper for the delivery of patient care and that their costs are reasonable.

(5) Franchise Arrangement

Maintain a copy of the franchise agreement and your analysis supporting the provider's identity and evaluation of specific services furnished and made available by a franchiser, for which the provider claims franchise fee expenses; or evidence that the provisions of the franchise agreement do not meet the conditions necessary to include franchise expenses.

(6) Provider's Certified Public Accounting Firm

Maintain the name of the provider's certified public accounting firm.

C – Accounting Policies

(1) Capital-Related Costs

Maintain copies of documents that include the areas of capitalization, relifing of depreciable assets, estimated useful lives of depreciable assets and componentized depreciation. Review capital-related costs for the following areas:

- Current year assets acquisitions;

- Consistency of capitalization;

- Gain/loss on disposal of assets; and

- Relifing of assets.

(2) Fixed Assets

Identify provider assets shown on the balance sheet. Usually, a listing of assets by class, e.g., land, buildings, equipment, indicating the acquisition date, the cost, useful life, method of depreciation, and the annual depreciation for each asset, is sufficient to support the asset and depreciation costs shown on the provider's financial statements.

Where such records are extensive, maintain at least a summary of the asset accounts, updated as required. Determine if fixed asset accounting is adequate and if depreciation is based upon guidelines included in PRM Chapter I, Part I.

(3) Loan or Mortgage Documents

Obtain copies (if practical) of all outstanding material loans or mortgages, or bond indentures to establish the allowability, necessity, and reasonableness of interest expense.

(4) Exceptions to Reimbursement Limitations

Evaluate provider requests for exceptions to reimbursement limitations (e.g., limitations on coverage of costs). Maintain a complete file to support exceptions, exemptions, and classification adjustments.

(5) Education Program Approvals

Approved educational activities means formally organized or planned programs of study operated by the staff of the institution. Include current copies of State licenses or professional organization recognition, to support the determination of the acceptance of graduate medical education, nursing school, and allied health programs.

(6) Insurance

Document the allowance of insurance costs regardless of whether they are for commercial, self-insurance, or alternative forms to provide full coverage. Include copies of policies where practical or pertinent extracts, copies of prior pertinent audit working papers, and/or a summary of the key provisions which fulfill the conditions for Medicare reimbursement.

(7) Preparation of Cost Reports

Determine whether the provider has the capability of preparing an acceptable cost report. Where a provider proposes a change from CMS' reporting procedure, determine whether it properly reflects Medicare cost reporting requirements and is acceptable to CMS and you.

(8) Deferred Compensation or Pension Plan

Have on file, for each provider having a deferred compensation or pension plan, a copy of the written agreement or extract and all amendments existing between the provider and participating employees which:

- Describes the method for determining all contributions to the fund;
- Describes the funding mechanism;
- Provides protection for the plan's assets;
- Designates the requirements for vested benefits;
- States the basis for determining the amount of benefits to be paid;
- Describes the treatment of such items as dividends, interest income, capital gains or losses in regard to the corpus of the fund; and
- Designates the handling of loan(s) made from the deferred compensation plan to the provider.

140.2 – Contractor Responsibility in Suspected Fraud or Abuse Cases

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

It is your responsibility to provide necessary guidance to providers in preparing their cost reports. If during your desk review and field audit activities you discover certain *items (e.g., expenses or allocation statistics for cost-reimbursed providers or cost-reimbursed areas of prospective payment system (PPS) providers, count of residents for graduate medical education or indirect medical education payments, bad debts,)* that are not allowable, make the necessary adjustments and inform the provider. Document all such adjustments made to the cost report.

If these same nonallowable items appear on a subsequent cost report, tell the provider again why they are disallowed. Confirm this notification in a letter. In this letter advise the provider that further insistence on including the same nonallowable items in the next cost report could result in referral to the U. S. Attorney General for consideration of criminal and/or civil prosecution. *(If the provider's payment system changed in the current year (e.g., from cost-reimbursed to (PPS) and the item(s) disallowed in the prior year no longer has any reimbursement impact in the current year, do not issue this letter.)*

Use the following model language.

On our audit for the period _____ to _____ certain items for which you receive reimbursement through the cost report were disallowed because they were determined by our auditors to be nonallowable. When we audited your cost report for the

period _____ to _____ we found the following *items which were disallowed in the prior period that were included in the computation of your cost report reimbursement:*

In our last meeting, we advised you which specific items were not allowed and the reason for the disallowance. Your further insistence on including these nonallowable *items* in future cost reports without disclosure as protested items could result in the referral of this situation to the U. S. Attorney General for consideration of criminal and/or civil prosecution.

Should you have any questions, please contact (contractor name).

If the provider continues to include these nonallowable *items* after receipt of the letter, follow your policies and procedures on fraud and abuse to refer the case to the Office of Program Integrity (OPI) of the responsible regional office.

However, if you have some support that even the initial insertion of a nonallowable item on the cost report was intended by the provider to defraud the United States government, no warning to the provider is required before referring the matter to the Office of the Inspector General (OIG) for investigation and possible prosecution.

Where you refer a questionable situation to the OPI or OIG, it is generally appropriate to continue the audit while the situation is investigated by the OIG. Occasionally, circumstances may require an audit to be discontinued pending the results of the investigation. These questions are resolved by CMS and the OIG.

Under no circumstances should you discuss a possible fraud or abuse situation with the provider, or take any action <u>to disallow</u> or resolve such questionable situation prior to receiving instructions from the OIG.

These instructions do not apply in situations where the provider disputes the allowability of an item and clearly indicates on the subsequent cost report that the particular item is still claimed as a protested item to establish the basis for an appeal.

Exhibit II – Audit Confirmation Letter

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Date

Addressee
Address
City, State Zip Code

Provider_____
Provider No:_____
F.Y.E.:_____

Dear _____

This is to inform you that your facility has been selected by (contractor name) for a field audit of your YYYY cost report. The audit will commence on MM, DD, YYYY, (4 to 6 weeks from the date of the letter) with an entrance conference to be held the day we arrive on site. Please arrange for a conference room or adequate space for this meeting. We ask that at the least the chief financial officer, the person who prepared the cost report, and anyone designated as your liaison for the audit is present at the entrance conference. In addition, we ask that the information listed on the attached schedule be available on the date we arrive. This list will enable you to accumulate the necessary documentation we will need to begin the audit prior to the entrance conference.

If you need to postpone the audit entrance date, please notify us 2 weeks prior to the scheduled audit and we will attempt to accommodate your request. This is necessary as our audit work plan has been set and we will need time to reschedule the audit staff. Again all documentation found on the attached list must be available at the entrance conference. This will enable us to review the information and expedite our audit process while minimizing the impact on your personnel. Be aware that this list is not all-inclusive and that we may request additional documentation necessary to conduct and complete our audit. If the information is not provided, we will make audit adjustments to disallow the costs associated with the requests.

Any proposed audit adjustments will be given to you during the course of the audit. You may request the work papers that support the adjustments at any time. A pre-exit conference will be held on the last day of the audit fieldwork *which is tentatively planned to be on MMDDYY* . In this meeting we will go over outstanding information requests and all of the audit adjustments available at that time. You will have 4 weeks to provide any outstanding information or information to refute any previously proposed audit adjustment. (We do not need to consider any additional documentation that you furnish

after the expiration of the 4-week period in the Notice of Amount of Program Reimbursement (NPR)). *We will schedule an exit conference within 8 weeks of receipt of this documentation. Prior to the exit conference, we will provide you with new or modified audit adjustments that we propose after the pre-exit conference and allow you two (2) weeks to comment on them.* If you wish to waive a formal exit conference, *please* notify *(name of contractor)* of this decision in writing *(e-mail note will suffice).*

The Notice of the Amount of Program Reimbursement will be issued to you within 60 days from the exit conference *or within 60 days from the date that we finalize the audit adjustments if an exit conference is waived.*

We believe these time frames and requirements will help expedite the completion of the field audit and settlement of your cost report. These provisions will be uniformly applied to all providers. We believe that with your cooperation we will have better field audits and more accurate settlements of cost reports.

If you wish to discuss this matter please contact _____ at _____.

Sincerely,

Signature, Title

Enclosures

cc:

Exhibit VII – Form of Report on Audit of Medicare Cost Report

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

CONTRACTOR LETTERHEAD

PROVIDER NAME _____

PROVIDER NUMBERS _____

REPORTING PERIOD FROM_____TO_____

We have audited the provider(s) Medicare cost report for the cost reporting period stated above.

We conducted our audit in accordance with *the directives in CMS Pub. 100-06, Chapter 8*. They require that we plan and perform the audit to obtain reasonable assurance that the cost report settlement reflects payment amounts and financial data in accordance with Medicare laws, regulations, and instructions.

A less than full scope audit was made of this cost report in accordance with CMS's audit instructions. The examination was confined to the specific areas selected for audit as indicated on the attached listing.

Preparation of the cost report and compliance with Medicare laws, regulations, and instructions is the responsibility of the provider(s) management. As part of obtaining reasonable assurance about whether the cost report settlement reflects payment amounts and financial data in accordance with Medicare laws, regulations, and instructions, we performed tests of compliance with certain provisions of the Medicare laws, regulations, and instructions.

In planning and performing our audit of the provider's cost report for the period, we considered its internal control structure, as it pertained to those items in the scope of our audit of the Medicare cost report, to determine auditing procedures for the purpose of expressing our opinion on the cost report and not to provide assurance on the internal control structure.

(Select one of the following alternative paragraphs on the consideration of the internal control structure, if applicable.)

We have concluded that it would be inefficient to evaluate the effectiveness of internal control structure policies and procedures and, in accordance with the GAS, we conducted

the audit more efficiently by expanding substantive audit tests, thus placing little reliance on the internal control structure.

or

The objectives of this financial related audit did not require an understanding of the internal control structure.

or

The existing internal control structure contained so many weaknesses we had no choice but to rely on substantive testing, thus virtually ignoring the internal control structure.

NOTE: This will not be included if the contractor used one of the alternative paragraph above.

The provider(s) management is responsible for establishing and maintaining an internal control structure. In fulfilling this responsibility, estimates and judgments by management are required to assess the expected benefits and related costs of internal control policies and procedures. The objectives of an internal control structure provide management with reasonable, but not absolute assurance that assets are safeguarded against loss from unauthorized use or disposition, and that transactions are executed in accordance with generally accepted accounting principles. Because of inherent limitations in any internal control structure, errors or irregularities may occur and not be detected. Also, projections of any evaluation of the internal control structure to future periods is subject to risk that procedures may become inadequate because of changes in conditions or that the effectiveness of the design and operation of policies and procedures may deteriorate.

For purposes of this report, we have classified the significant internal control structure policies and procedures, as they affect the Medicare audit in the categories listed in the attached report.

For the internal control structure categories listed, we obtained an understanding of the design of relevant policies and procedures and whether they have been placed in operation, and we have assessed control risk.

(If reportable conditions were noted, the contractor incorporates the following statement, along with paragraphs describing the reportable conditions.)

We noted certain matters involving the internal control structure and its operation that we consider to be reportable conditions under standards established by the American Institute of Certified Public Accountants. Reportable conditions involve matters coming to our attention relating to significant deficiencies in the design or operation of the internal control structure that, in our judgment, could adversely affect the entity's ability

to record, process, summarize, and report financial-related data consistent with the assertions of management in the Medicare cost report.

Our consideration of the internal control structure would not necessarily disclose all matters in the internal control structure that might be material weaknesses under standards established by the American Institute of Certified Public Accountants. A material weakness is a reportable condition in which the design or operation of the specific internal control structure elements does not reduce to a relatively low risk that errors or irregularities in amounts that would be material in relation to the cost report being audited may occur and not be detected within a timely period by employees in the normal course of performing their assigned functions.

(If no material conditions or reportable conditions were noted, the contractor incorporates the following statement.)

We noted no matters involving the internal control structure and its operation that we consider to be material weaknesses as defined above.

(The following paragraph is an optional paragraph under either consideration for items that are less than reportable conditions and for general comments.)

However, we noted certain matters involving the internal control structure and its operation that we have reported to the provider's management in a separate letter dated (the contractor inserts the date of the letter).

The results of our tests indicate that, with respect to the items tested, the provider(s) complied in all material respects with Medicare laws, regulations, and instructions, except for the items listed in the attached adjustment report. With respect to items not tested, nothing came to our attention that caused us to believe that the provider(s) has not complied in all material respects with these provisions.

The attached Medicare cost report has been adjusted for these items of noncompliance in accordance with the attached audit adjustment report.

This report is intended for the information of the provider(s) and CMS. This restriction is not intended to limit the distribution of the report, which is a matter of public record, unless otherwise restricted by applicable laws.

(Signature)

Name and Title

NPR Date

20.1 – Provider Summary Report

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

Guidelines for provider/intermediary use of the year-to-date PS&R provider summary reports are contained in §§10.1 and 90 of Chapter 8 of this manual.

20.2 – Payment Reconciliation Report

(Rev. 60, Issued: 11-26-04, Effective: 10-01-04, Implementation: 01-24-05)

The payment reconciliation report provides detailed data that supports the provider summary report. See *§10.1 of Chapter 8 of this manual for instructions on the use of this report.*

R	8/110/Audit Responsibility When Provider Changes Contractors
R	8/120/Audits of Home Offices
R	8/120/6/Standards for Issuance of an Audit Report for a Home Office
R	8/130/Provider Permanent File
R	8/140/2/Contractor Responsibility in Suspected Fraud or Abuse Cases
R	8/170/Exhibit II/Audit Confirmation Letter
	8/170/Exhibit VII/Form of Report on Audit of Medicare Cost Report
R	9/20/1/Provider Summary Report
R	9/20/2/Payment Reconciliation Report

III. FUNDING: Medicare contractors shall implement these instructions within their current operating budgets.

IV. ATTACHMENTS:

X	**Business Requirements**
X	**Manual Instruction**
	Confidential Requirements
	One-Time Notification
	Recurring Update Notification

***Unless otherwise specified, the effective date is the date of service.**