SUBJECT: Instructions for Conducting In-House Audits and Revision to Part II Acceptability Checklist Requirements

I. SUMMARY OF CHANGES: Implementation of In-House Audits that allow contractors to conduct cost report audits either in-house or at the provider's location. Revision to Acceptability Checklist procedures that require the contractors to only complete Part I of the Acceptability Checklist. At the contractor's discretion, it may be implemented upon issuance immediately or required no later than October 2, 2006.

NEW / REVISED MATERIAL
EFFECTIVE DATE: October 1, 2006
IMPLEMENTATION DATE: October 2, 2006

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. 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 is not updated)
R=REVISED, N=NEW, D=DELETED-Only One Per Row.

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<thead>
<tr>
<th>R/N/D</th>
<th>Chapter / Section / Subsection / Title</th>
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</thead>
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<td>R</td>
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<td>R</td>
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<td>R</td>
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</tr>
<tr>
<td>R</td>
<td>8/50/Scoping/Planning of Individual Field and In-House Audits</td>
</tr>
</tbody>
</table>
III. FUNDING:
No additional funding will be provided by CMS; Contractor activities are to be carried out within their FY 2006 operating budget.

IV. ATTACHMENTS:

Business Requirements
Manual Instruction

*Unless otherwise specified, the effective date is the date of service.*
SUBJECT: Instructions for Conducting In-House Audits and Revision to Part II Acceptability Checklist Requirements.

I. GENERAL INFORMATION

A. Background: Previously FIs conducted cost report audits at the provider’s location. This change request allows FIs to conduct cost report audits either in-house or at the provider’s location. Previously contractors completed Part I and Part II of the Acceptability Checklist. Contractors will now only be required to complete Part I of the Acceptability Checklist.

B. Policy: Legal authority for the CMS audit instructions is found in Medicare regulations published at 42 CFR 413.24 and 42 CFR 421.100.

II. BUSINESS REQUIREMENTS

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

<table>
<thead>
<tr>
<th>Requirement Number</th>
<th>Requirements</th>
<th>Responsibility (“X” indicates the columns that apply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5262.1</td>
<td>The contractor shall complete Part I Acceptability Checklist to determine the acceptability of the provider’s cost report. (Section 10.3)</td>
<td>X X</td>
</tr>
<tr>
<td>5262.1.1</td>
<td>The contractor shall no longer complete Part II of the Acceptability Checklist. (Sections 10.3 and 20.2)</td>
<td>X X</td>
</tr>
<tr>
<td>5262.1.2</td>
<td>If the provider does not submit the required information with its cost report and the contractor needs this information, it shall be requested from the provider allowing at least seven (7) work days to submit it. (Section 10.3)</td>
<td>X X</td>
</tr>
<tr>
<td>Requirement Number</td>
<td>Requirements</td>
<td>Responsibility (&quot;X&quot; indicates the columns that apply)</td>
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<td>F</td>
</tr>
<tr>
<td>5262.2</td>
<td>The contractor shall perform a field audit or an in-house audit based on their discretion. (Section 30).</td>
<td>X</td>
</tr>
<tr>
<td>5262.2.1</td>
<td>The contractor shall conduct in-house audits using the same standards/processes as field audits. (Section 30.1).</td>
<td>X</td>
</tr>
<tr>
<td>5262.3</td>
<td>The contractor shall send the provider an audit confirmation letter for all in-house or field audits and advise the provider of the items that are required prior to starting the audit as well as identifying the major areas to be reviewed during its audit. (Section 60.1).</td>
<td>X</td>
</tr>
<tr>
<td>5262.4</td>
<td>The contractor shall conduct a telephone entrance conference for in-house audits. (Section 60.2.2).</td>
<td>X</td>
</tr>
<tr>
<td>5262.5</td>
<td>The contractor shall indicate at the top of the UDR Summary of Issues that an In-House audit was performed. (170-Exhibits-Exhibit I).</td>
<td>X</td>
</tr>
<tr>
<td>5262.6</td>
<td>The contractor shall indicate in their audit confirmation letter that an in-house audit will be performed. (170-Exhibits-Exhibit II b).</td>
<td>X</td>
</tr>
</tbody>
</table>

### III. PROVIDER EDUCATION

| Requirement Number | Requirements | Responsibility ("X" indicates the columns that apply) |
IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

<table>
<thead>
<tr>
<th>X-Ref Requirement #</th>
<th>Instructions</th>
</tr>
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<tbody>
<tr>
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</table>

B. Design Considerations: N/A

<table>
<thead>
<tr>
<th>X-Ref Requirement #</th>
<th>Recommendation for Medicare System Requirements</th>
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</thead>
<tbody>
<tr>
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</table>

C. Interfaces: N/A

D. Contractor Financial Reporting /Workload Impact: N/A

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

<table>
<thead>
<tr>
<th>Effective Date*: October 1, 2006</th>
<th>No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.</th>
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<tbody>
<tr>
<td>Implementation Date: October 2, 2006</td>
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<tr>
<td>Pre-Implementation Contact(s): Dorothy Grothe, (410) 786-0186 or <a href="mailto:dorothy.grothe@cms.hhs.gov">dorothy.grothe@cms.hhs.gov</a></td>
<td></td>
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<tr>
<td>Post-Implementation Contact(s): Dorothy Grothe, (410) 786-0186 or <a href="mailto:dorothy.grothe@cms.hhs.gov">dorothy.grothe@cms.hhs.gov</a></td>
<td></td>
</tr>
</tbody>
</table>

*Unless otherwise specified, the effective date is the date of service.
10.3 – Acceptance of Medicare Cost Report

(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

The contractor is required to make a determination of acceptability within 30 days of receipt of the provider’s cost report. (See 42 CFR 413.24(f)(5)(iii)). The Uniform Desk Review (UDR) program (see §20.2.A of this chapter) contains Part 1 Acceptability Checklist that can be used to make that determination. Failure to supply all the following items (enumerated in PRM-II, Section 140) will cause the cost report to be rejected.

For all providers filing electronic cost reports (ECRs):

1. A diskette (or other media as permitted in PRM-II, §130.2) of the ECR utilizing CMS-approved vendor with the current specification date submitted. (See PRM-II, §140 regarding bad or damaged cost report diskette.)

2. An ECR that passes all Level 1 edits.

3. A submitted print image file of the cost report except when using CMS free
software.

4. The certification page (Worksheet S) of the ECR file with the original signature (not a facsimile or stamped copy of the signature) of an officer (administrator or chief financial officer).

5. An exact match of the encryption code, date and time for the ECR displayed on the certification page to that of the ECR file encryption code, date and time.

6. An exact match of the encryption code, date and time for the print image displayed on the certification page to that of the print image file encryption code, date and time except when using CMS free software.

7. For teaching hospitals, a complete Intern and Resident Information System (IRIS) diskette that will pass all IRIS system edits.

8. The settlement summary on the electronic certification page agrees with the settlement summary on the Medicare cost report produced from the electronic file. (Prior to rejection confirm that the settlement summary difference is not caused by the contractor-automated data reporting (ADR) vendor system.)

9. A completed Form CMS-339 with an original signature of an officer or administrator.

For all other providers:

1. A completed and legible cost report on the proper forms that is mathematically correct.

2. A general information and certification page which includes the original signature of an officer (administrator or chief financial officer).

3. A completed Form CMS-339 with an original signature of an officer or administrator.

In addition to the items enumerated above, providers are requested to submit other documentation that may be required to complete a desk review. However, failure to supply any or all of those items is not a basis for rejection of the cost report. Contractors previously verified the seven items listed below (also detailed in PRM-II, Section 140) were submitted by completing Part II of the Acceptability Checklist. Completion of Part II of the Acceptability Checklist is optional from the date of this change memorandum until October 2, 2006. Effective October 2, 2006, contractors shall no longer complete Part II of the Acceptability Checklist.

1. Correctly updated graduate medical education (GME) per resident amounts, where applicable.
2. All applicable documentation required in instructions to Form CMS-2552-96 (hospitals).

3. All documentation per Form CMS-339 required for the provider’s type.

4. Documentation supporting exceptions to level 2 ECR and healthcare cost report information system (HCRIS) edits.

5. A copy of the working trial balance for nonhospital providers (this is covered in Item 2 for hospitals).

6. A copy of the audited financial statements, where available.

7. Supporting documentation for reclassifications, adjustments, related organizations, and protested items for nonhospital providers (this documentation is covered in Item 2 for hospitals), where applicable.

If you determine you need any of the above information, and it was not submitted with the cost report, you shall request the information from the provider allowing at least seven (7) work days to submit it.

20.1 – Definition
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

The desk review is an analysis of the provider’s cost report to determine its adequacy, completeness, and accuracy and reasonableness of the data contained therein. It is a process of reviewing information pertaining to the cost report without detailed verification and is designed to identify problems warranting additional review and, where appropriate, to resolve some of those problems/exceptions. The objective of the desk review is to determine whether the cost report can be settled without an audit or whether an in-house or field audit is necessary. For this purpose, every desk review should contain a summary of the review results (see Exhibit I in §170 of this chapter) and a decision as to the next step (e.g., settle without additional review, complete desk review exception resolution, perform in-house or field audit). If a decision is made to audit the cost report, a properly completed desk review is essential for planning the audit and establishing the audit objectives.

Desk reviews are required for all providers filing a Medicare cost report except Hospice and low/no Medicare utilization providers. However, if your professional judgment dictates, you may perform an appropriate desk review (see §§20.2.C-E) on a low Medicare utilization cost report. Use the specific CMS Uniform Desk Review program that is in effect at the time you are performing the desk review for each provider. The following information, as appropriate, may assist you in completing the specific desk review steps and later in planning the audit (see §50.1 of this chapter).
• Permanent File;
• Correspondence Files;
• PS&R;
• Current and Prior Year Medicare Cost Reports;
• Working Trial Balance;
• Financial Statements;
• Provider Cost Report Questionnaire (Form CMS-339);
• Prior Year Audit Notes;
• Prior Year Audit Adjustment Report; and
• Prior Year Audit Working Papers.

20.2 – Components of the Uniform Desk Review (UDR)
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

The UDR is comprised of an acceptability checklist, a clerical review, selection of professional desk review type, either a limited professional desk review or a full professional desk review, and a summary of UDR exceptions.

NOTE: The UDR is issued by CMS separately and is not included in this manual.

A. Acceptability Checklist

Complete the appropriate Acceptability Checklist for the type of provider submitting the cost report for all cost reports received. The objective of the Acceptability Checklist is to determine whether the provider has submitted a complete cost report, Form CMS-339, IRIS diskette, if applicable, and that the electronic cost report passes all Level I edits. Note: Effective October 2, 2006, Part II of the Acceptability Checklist shall be eliminated and only Part I of the Acceptability Checklist is required to be completed by the contractor.

Follow the instructions in §10.3 of this chapter pertaining to rejection of a cost report and the manner in which to handle missing items that are requested but not required for acceptance of the cost report.
Ensure that the completed Acceptability Checklist is given to the individuals responsible for completion of the remainder of the UDR. When all the workpapers prepared to settle the cost report are completed, include the completed Acceptability Checklist in your desk review workpaper files. Indicate the location, within your working paper files, of the documents that the provider submitted with the cost report if they are not included in the same section as the Acceptability Checklist.

B. Clerical Review

A clerical desk review consists of the following:

- Verification of the mathematical accuracy of the submitted cost report through footings, cross-footings, and calculations for those cost reports that are not filed electronically. Clerical errors are to be corrected and noted in total as adjustments for the purpose of final settlement. If extensive clerical errors exist in the cost report that may require a significant amount of time to correct, the cost report may be returned to the provider for correction on the basis that the provider failed to submit an acceptable cost report. (See §10.3 of this chapter.)

- Preparation of a comparative analysis of the cost report data between the prior and current year when needed for a full professional desk review.

C. Selection of Professional Desk Review Type

Selection of the appropriate type of professional desk review is critical in making the desk review/audit process more efficient and economical. Accordingly, select the appropriate professional desk review (limited or full) based on provider type and thresholds in accordance with the instructions contained in the UDR program.

Currently only a limited professional desk review is required for Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs). Thresholds are applied to the cost reports of other types of providers to determine whether a limited or full professional desk review should be completed.

The thresholds published in the UDR are recommended guidelines that CMS expects the contractors to implement. However, if you believe the published thresholds are inappropriate to a specific situation or to a provider group, you may request an approval from the CMS regional office to change those thresholds. Your request must contain a justification for the change. The regional office will either approve or disapprove the request in writing.

D. Limited Professional Desk Reviews

Appropriate limited professional desk review (depending on provider type) is completed for cost reports filed by providers other than hospitals that are almost entirely reimbursed under PPS or the fee screen. It may also be completed for cost reports filed by PPS
hospitals and cost reimbursed providers (including hospitals) that fall below the desk review thresholds established by CMS. (See §20.2.C of this chapter.)

The UDR contains separate limited professional desk review programs for hospitals, SNFs, HHAs, and outpatient facilities. All the areas/issues in these programs must be addressed by the contractor because they are limited to only those that are essential in those cost reports. However, these UDRs contain specific thresholds for most of the areas/issues, thus all the steps may not have to be completed.

E. Full Professional Desk Reviews

A full professional desk review is an analysis of the cost report and the provider’s background. Its completion creates and documents an immediate awareness of changes, open issues, and problem areas.

The full professional desk review is completed for cost reports filed by providers other than SNFs and HHAs if they exceed the desk review thresholds established by CMS. (See §20.2.C of this chapter.) However, you are not prohibited from completing a full professional desk review on a cost report for any of those providers even if it falls below the desk review thresholds if your professional judgment so dictates. In this situation, you must document the reason for performing a full professional desk review.

The UDR contains separate full professional desk review programs for hospitals and outpatient facilities. These programs contain thresholds for most of the areas/issues addressed therein, thus all the steps (even if the area/issue is applicable) may not have to be completed. Furthermore, the individual review steps for each reimbursement issue may be expanded or omitted as necessary to address specific circumstances. However, the reasons for omitting steps must be documented. If expansion is necessary, try to limit any changes to the full professional desk review to the information readily available in the cost report (including Form CMS-339 Provider Cost Report Reimbursement Questionnaire), prior audit files, if any, and the permanent reference file.

F. Summary of UDR Issues

Use the “Uniform Desk Review - Summary of Issues” worksheet (see Exhibit I in §170 of this chapter) to list the exceptions identified through the UDR process. You may use an alternative format if it contains, at a minimum, the information in Exhibit I.

Number each exception in the first column. This facilitates future cross-referencing of issues flowing through audit, settlement, and if applicable the appeals process. In column 2 identify the UDR section and the step/question specific to the exception. If in your judgment there are other issues that did not surface as desk review exceptions but need to be considered as possible audit issues, list them after the desk review exceptions at the bottom of this exhibit. Continue numbering them in Column 1 as though they are desk review exceptions but identify them as “other” in Column 2. In Column 3 write a brief
description of the issue for each item listed in Column 1 (both desk review exceptions and other exceptions).

Where applicable, insert the units and/or dollar amounts pertaining to each exception in column 4. Leave column 4 blank in situations where the amount cannot be established at the time of the desk review.

Do not transfer mathematical errors (i.e., footing, cross-footing, tracing, calculations) to this schedule. They remain on the appropriate clerical worksheets as exceptions. (See §§ 20.2.B and 10.3 of this chapter.)

Use columns 5 through 7 to document the audit selection and scoping process for those issues that could not be resolved during the desk review. Explain the basis for those decisions in column 9 (Comments) and reference the working paper(s) documenting the decision in Column 10. For example, if column 5 or 6 was checked, give reason such as immaterial, budgetary constraints, etc. in column 9 and in Column 10 reference the working paper documenting the process used to arrive at that decision. (See §50.1 of this chapter containing instructions for scoping the field audit.) Where the item is scoped for audit, also outline the audit requirements and objectives in column 9.

If an exception was resolved during the desk review explain this in Column 9. If an adjustment resulted from the desk review exception resolution, annotate this in Column 8 and prepare an adjustment. Record this adjustment in the audit adjustment report (see Exhibit VI in §170 of this chapter).

Identify the audit or desk review exception resolution working paper where the exception was addressed in column 10 (UDR Resolution or Audit W/P Ref).

Indicate in the designated boxes at the top of the "UDR Summary of Issues" the decision regarding the next step for the cost report (e.g., in-house audit, field audit, settlement without further review). The rationale for the decision should be consistent with the plan used to formulate the audit budget for the fiscal year. (See §§ 40ff and 50ff of this chapter.)

20.3 – Desk Review Exceptions Resolution Process
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)
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 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 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 – Field and In-House Audits
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

Providers receiving payments under Part A and B of Title XVIII of the Act, as amended are subject to audit of payments applicable to services rendered to Medicare beneficiaries. An audit may be done as a field audit or as an in-house audit based on the discretion of the contractor.

30.1 – Definition of Field and In-House Audits
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

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.

An in-house audit is an examination of financial transactions, accounts, and reports as they relate to the Medicare cost report to test the provider’s compliance with applicable Medicare laws, regulations, manual instructions, and directives that is performed at the contractor’s location. The in-house audit usually requires limited records. An in-house audit is subject to the same standards/processes and requires the use of an audit program. In general, an in-house audit is the same as a field audit except all work is performed at the contractor’s location. (See Section 60).

In performing Medicare in-house and field audits, 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 both in-house and field audits 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 in-house and field audits are 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 and In-House Audits
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

Medicare in-house and 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.

40 – Planning and Management (Global Scoping)- Field and In-House Audits
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

The audit work plan and selection process is influenced by the budgetary restrictions imposed upon you by CMS. Annually, through the budget process and the Budget Performance Requirements (BPRs), CMS gives you guidance for managing audit resources in terms of areas of concentration and dollars available to accomplish the tasks. Develop an audit plan to identify cost reports to be audited and resources to be expended, taking into consideration the guidance that CMS gives you in §40.1 of this chapter and the BPRs about the types of providers or potential issues to be audited. However, do not use these priorities as the sole determining factor in the planning process. The planning process is based on your empirical knowledge, past performance of the provider, last time audited, and the relative risk associated with the settlement amount calculated from the cost report. Generally, select providers for audit that, based on your professional judgment, represent the greatest risk for incorrect payment.

Effective management of audit resources requires a continual decision-making process. As events occur throughout the audit cycle and circumstances come to light, the audit plan must be continually evaluated and priorities reassessed. If a greater audit requirement becomes evident, do not defer that audit work. Rather, defer or cancel audit work of lesser urgency. If there is no work of lesser urgency, seek guidance from the RO.

Apply the appropriate level of resources for each audit to assure that payments made to a provider are not more or less than required under applicable law and regulations to achieve CMS's audit objectives. If you are unable to meet both the quantity and quality
standards, seek guidance from your regional office (RO) on the extent to which you may deviate from your budget/plan while maintaining audit quality.

You are expected to accomplish the goals outlined in the BPRs to the extent that other audit needs that are discovered during the year do not outweigh these goals. Use professional judgment to communicate workload adjustment needs to your RO. Monitor your progress on BPRs and discuss the impact of any problems that may develop in meeting the BPRs with your RO.

50 – Scoping/Planning of Individual Field and In-House Audits
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

50.1 – Establishing the Objective/Scope of the Field and In-House Audits
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

Once you make a decision to perform an in-house or 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 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 your 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.

50.2 – Tailoring of the Audit Program
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

An audit program provides the audit procedures that auditors must follow to achieve the audit objectives. Prepare a specific audit program for each in-house or field audit that you perform. This audit program should reflect the issues/areas contained in the scoping document (e.g., the Summary of UDR Exceptions described in §20.2.F of this chapter). (Use the CMS hospital, home health agency and skilled nursing facility audit programs in effect at the time you prepare the audit program as a guide. These programs are not contained in this manual as CMS releases them separately.)

Your audit program must:

- Identify your audit objectives;
- Identify the issues, transactions or cost report entries to be audited, reviewed or verified;
- Identify the audit steps to be performed;
- Describe the tests to be applied.

60 – Field or In-House Audit Process
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

60.1 – Audit Confirmation Letter (a.k.a. Engagement Letter)
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

The contractor must send the provider an audit confirmation letter for all in-house or field audits. This document will advise the provider of the items that are required prior to
starting the audit as well as identifying the major areas the contractor intends to review during its audit.

60.1.1 – Audit Confirmation Letter (a.k.a. Engagement Letter) - Field Audit (Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

The field 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.

60.1.2 – Audit Confirmation Letter (a.k.a. Engagement Letter) - In-House Audit (Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

The in-house audit confirmation letter should give a minimum of 4 weeks and a maximum of 6 weeks notice of the contractor’s intent to conduct an in-house 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:
• Identification of the major areas the contractor will review.

• A list of the required documents and the due date that provider must send copies of the documentation to the contractor. The provider should be given at least 3 weeks to provide the requested documents, and the due date should be at least a week prior to the telephone entrance conference.

• Date and time of the telephone entrance conference. (Enclose the telephone 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 telephone conference date should be set within a week of the anticipated completion date of all audit review work. (Enclose the pre-exit conference format – Exhibit V in § 170 of this chapter).

• Notice that a telephone exit conference will be conducted once all audit adjustments are finalized.

• Notice to the provider that all documentation and records requested 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. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

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 participants 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).

60.2.1 – Entrance Conference for Field Audit
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

During the on-site 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 *on-site* audit and schedule the pre-exit conference.
- Discuss the scope of the *on-site* 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.

**60.2.2 – Entrance Conference for In-House Audit**  
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

*During the telephone entrance conference, explain the purpose of the in-house 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. However all reopenings are at the discretion of the contractor. Additionally, address the following during the entrance conference.*

- Discuss timeframes for conducting the in-house audit and schedule the pre-exit conference.
- Discuss the scope of the in-house 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;

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

• Discuss timeframes for additional documentation that is requested during the audit. All requests should be in writing which could either be e-mailed or faxed to the designated provider’s liaison. In general, the provider should be given three (3) to five (5) working days to supply the requested additional documentation.  

  Note: All contractor requests and provider responses must follow PHI/HIPAA requirements when emailing or faxing information.

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

60.5 – Coordination of Activities During the Field and In-House Audits (Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

In order to ensure that the in-house or field audit will accomplish its objectives, it is important to have the provider designate a staff person to serve in the role of the audit liaison. This person assures that issues are addressed as they arise rather than at the completion of the audit. The provider liaison performs an active role during the audit. This person either provides requested information or ensures that the appropriate and responsible individual(s) on the provider's staff is made aware of the request for additional information.

Your principal goal in carrying out the audit responsibilities is to arrive at a correct settlement of the cost report. In doing so preserve both the provider's interest and government's interest. If during the audit you uncover circumstances in which a provider disadvantaged itself, advise the provider liaison of the issue(s). Also, maintain ongoing communications during the audit by discussing regularly with the provider liaison to handle the following:

• Requests for documentation that were not mentioned in the audit confirmation letter and were not requested during the entrance conference;

• Follow up on your requests for additional information. The provider should respond in writing if they cannot comply with the agreed upon response date;

• Open audit issues, proposed audit adjustments and/or the general progress of the audit. Provide the audit liaison with the audit adjustments, including those being
proposed due to lack of documentation, and the related working papers (if requested by the provider) during the course of the audit.

60.7 – Evidence
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

The AICPA fieldwork standard on evidence for a financial related audit states that: "Sufficient competent evidential matter is to be obtained through inspection, observation, inquiries, and confirmations to afford a reasonable basis for an opinion regarding the financial statements under examination."

The GAS fieldwork standard on evidence for a financial related audit states that: “A record of the auditors’ work must be retained in the form of working papers.”

While the Medicare auditor does not express an opinion on financial statements, he/she is responsible for collecting sufficient and competent evidential data as a basis for drawing conclusions about the Medicare cost report. Ensure that evidence obtained during the course of the in-house or field audit is sufficient to enable the auditor to support conclusions, adjustments, and recommendations. Make sure that there is enough factual and convincing evidence so that a prudent person can arrive at the same conclusion of fact as the auditor. In addition, evidence must be competent and relevant. That is, evidence must be valid and reliable and have a logical relationship to the issue/subject under review.

A. Sources and Categories of Evidence

Review all evidence, no matter from what source, with appropriate professional skepticism. The auditor must keep an open mind, but must question the validity of all evidence and must determine its application to the situation under review. In addition, evidence uncovered by an auditor that the provider has used in another situation, such as a bank loan application, public stock filing, insurance claim, other government reports (e.g., tax returns, SEC filings), or reports from an outside agency have greater credibility than conflicting or self-serving evidence offered by the provider concerning the audit.

Obtain sufficient, competent evidence to ensure the propriety of costs claimed by the provider on its submitted Medicare cost report in order to determine that proper payment is made for services provided to Medicare beneficiaries. The evidence consists of physical inspection or observation and corroborating documents such as checks, invoices, contracts, vouchers, assignment/rotation schedules for interns and residents, minutes of meetings, and written or oral testimony of provider employees.

Base your audit tests on the best evidence available. Consider the probative value of evidence offered in context of the hierarchy of order and types of evidence. Never rely on evidence of a lower order or type if you can reasonably conclude that evidence of a
higher order or type is available. Insist that providers produce evidence of the highest order and type that you believe is available.

Categories of evidence include:

- **Physical Evidence.**—This is obtained from direct observation or inspection of property, equipment, inventory, cash, activities, or events. However, in certain circumstances, physical evidence may not be sufficient, especially if the auditor has to rely on personal knowledge to determine the propriety or value.

- **Documentary Evidence.**—This type of evidence is the most commonly used and referred to by an auditor. It is created information such as letters, contracts, accounting records, invoices, checks, interns’ and residents’ rotation schedules, etc.

- **Analytical Evidence.**—This is developed by the auditor through calculations, analysis, comparisons, and reasoning. It can be used to test the provider's calculations, account breakdowns, statistics, and allocations.

- **Testimonial Evidence.**—This is probably the least reliable type of evidence. It is obtained from others, both inside and outside the provider's organization, through responses to inquiries and interviews. (By itself, this category of evidence is unacceptable for Medicare purposes. Therefore, evaluate all such information and corroborate with additional evidence.)

In evaluating the effectiveness and usefulness of evidence, consider whether the audit objectives have been achieved. If the audit objectives were not achieved, the evidence was either not sufficient or was only sufficient to establish that there was a problem. Obtain additional evidence in order to reach a valid conclusion and achieve the audit objective.

If there is sufficient and reliable evidence that supports a conclusion that the provider’s reported reimbursement amount for a specific area is incorrect, make an appropriate adjustment and document it in the working papers. Likewise, if the provider does not furnish sufficient and reliable evidence to support the reported reimbursement amount for a specific area, make an adjustment to disallow the reimbursement in question. (See 42 CFR 413.20(a), 42 CFR 413.24(a), and §§60.10, 60.11, and 60.12 of this chapter.)

**60.9 – Documentation Standards**  
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

Documentation that the evidence obtained, procedures applied, and tests performed provide sufficient, competent, and relevant evidence to support the auditor’s opinions, judgments, conclusions, or recommendations is essential. After obtaining and testing the various types of evidence (e.g., invoices, bills, contracts, statistics such as the FTE
number of interns and residents) considered necessary in the circumstances, retain at least a representative sample of such evidence. If only a sample of the evidence for each area of in-house or field audit is retained, refer to evidence not retained and its relationship to the basis for the opinions, judgments, conclusions, or examinations.

Where audit adjustments were made, auditors should include in the working papers, copies of provider documents that were reviewed. For those documents not copied, auditors may meet GAS requirements by listing voucher numbers or check numbers. As an example, if voucher numbers or check numbers are used as a means of identification, sufficient documentation should consist of also listing the respective dates paid, amounts paid, and descriptions of the items for which the vouchers or checks were issued. Where audit adjustments were not made, auditors must include in the working papers copies of a representative sample of documents examined. Where materiality is a factor, define "materiality" within the scope and objective of your review/audit.

These documentation standards apply to both the desk review, in-house and field audits.

60.10 – Pre-Exit Conference
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

Conduct a pre-exit conference on the last day that the audit team is conducting the fieldwork or the date established at the entrance conference. 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) from the end of the 4 week period given to the provider to provide additional documentation.

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

60.12 – Exit Conference
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

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 participating in 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 participate.
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.

60.13 – Supervision During the Audit Process
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

The Government Auditing Standards related to performance of audits state that: "Staff are to be properly supervised." and "Supervision involves directing the efforts of auditors and others who are involved in the audit to determine whether the audit objectives are being accomplished. Elements of supervision include instructing staff members, keeping informed of significant problems encountered, reviewing the work performed, and providing effective on-the-job training."

A. Staff Supervision

Direct supervision of staff during the audit by a qualified supervisor is necessary to ensure that the audit is completed in accordance with the audit work plan. Proper supervision must be a constant activity during the desk review process, planning and completion of the audit, preparation of the audit report, and settlement of the cost report. Supervision is required so that each member of the audit team understands the objective of each desk review/audit procedure, how to perform and document the completion of the audit procedure in the working papers, and how to evaluate the audit evidence. 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.

You must also provide guidelines 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.

Furthermore, you must provide procedures for reviewing audit working papers and reports.

B. Hiring

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

C. Supervisory Review Standards for Working Papers

The audit working papers and associated files (e.g., permanent file) are the only evidence of the audit procedures you performed to support your decision on the accuracy of the final settled Medicare cost report.

An element of supervision is a thorough supervisory review of the audit working papers. This may require several levels of review, depending on the size and configuration of the audit organization. For example, in a larger organization, the in-charge auditor is responsible for reviewing the work of other auditors on the team, and an independent supervisor reviews all work performed during the audit. While the ideal situation would have this second level review performed by an audit supervisor, the individual performing that function need not have that title. Rather, the individual may be a highly
qualified senior auditor who is not part of the team performing the audit. In addition, a manager may also perform a subsequent higher-level review of the completed work.

Your responsibility to review the audit working papers includes audits performed by all your employees and by individuals who are not your employees (i.e., subcontractors) regardless of the arrangements under which they perform the audits. You cannot delegate the responsibility to perform independent review of a subcontractor even if the subcontractor is another fiscal intermediary.

The supervisory review also satisfies the audit standards requirement for due professional care in performing the audit. The first level of defense to ensure the quality of the working papers is the on-site supervision of the audit staff. The second level of defense to ensure the quality of the working papers is the supervisory review. No improvement in the quality of the audit work will occur unless management recognizes the importance of the working paper review, as the second most important line of defense in maintaining quality working papers. Proper supervisory review:

- Ensures that the audit is completed in accordance with the audit plan;
- Minimizes contradictions within the audit working papers;
- Minimizes inappropriate or inaccurate interpretation of Medicare policies; and
- Assists in the evaluation and development of staff.

Give the supervisory reviewer adequate time to complete a competent review. No matter how knowledgeable the reviewer is, the effectiveness of the review is directly proportionate to the time spent on the review. The reviewing supervisor must have sufficient knowledge and understanding of the following:

- Medicare laws, regulations, and payment policies;
- Medicare cost reporting requirements;
- GAS and the AICPA SAS; and
- Provider accounting procedures.

D. General Approach to Supervisory Review of Audit Working Papers

The reviewing supervisor must:

- Be critical and not perfunctory;
- Be methodical, careful, and thorough;
• Ensure that the working papers support the audit objectives;

• Question the stated conclusions and be able to arrive at the same conclusions, based on the evidence presented on the working papers; and

• Have a clear understanding of materiality and spend proportionately more time on material issues.

E. Specific Points in the Supervisory Review of Audit Working Papers

While the following points are not all-inclusive, the reviewing supervisor should:

• Obtain an overall understanding of the provider by reviewing its correspondence file, permanent file, financial statements, and as-filed cost report;

• Understand the audit work plan as determined by the desk review and the resulting scope of audit, as detailed in the audit program;

• Discuss the in-house or field audit with the in-charge auditor to determine areas in which the auditors had problems;

• Ensure that the audit work plan is completed;

• Ensure that decisions to defer audit steps identified in the initial audit scope are adequately documented;

• Ensure that the working papers meet the mechanical and analytical requirements for quality working papers (see §60.8 of this chapter);

• Ensure that Medicare payment policies are properly interpreted;

• Ensure that conclusions are supported by sufficient, competent, and relevant evidential matter;

• Ensure that conclusions drawn from the audit procedures are supported by the work performed;

• Ensure that the provider has been advised of proposed adjustments and given sufficient time to respond;

• Ensure that all the retained adjustments are incorporated in the adjustment report;

• Ensure that the aggregate of all adjustments passed as immaterial do not have a significant impact on Medicare payment;
• Test calculations which have a direct impact on Medicare payment;

• Look for areas which require more in-depth audit in subsequent audits and determine how they were addressed;

• Ensure that notes for future audits are prepared and included in the permanent reference file;

• Prepare review notes;

• Make a final check of the working papers after the review notes are cleared;

• Ensure that unnecessary papers are deleted from the working paper file;

Retain supervisory review notes in the working papers.

70.1 – Content and Structure of the Medicare Cost Report Audit Report
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

Complete the audit report on your letterhead paper specifying the name of the provider or provider complex whose Medicare cost report was audited. Include the provider and subprovider numbers for all components reported on the Medicare cost report for the provider complex. Also, include either a separate notice of program reimbursement (NPR) for each provider and subprovider component, or one NPR for the entire complex, identifying the provider/subprovider component name, number, and cost reporting period.

In preparing the Medicare audit report, you will:

• Ensure that the audit report complies with Government Auditing Standards (GAS) requirements (see Chapter Five of the “Government Auditing Standards” entitled “Reporting Standards for Financial Audits);

• Incorporate statements of positive and negative assurance for compliance with Medicare laws, regulations and instructions;

• Designate those individuals authorized to sign such reports;

• Incorporate statements referring to your consideration of the provider's internal control structure in planning substantive audit tests;

• Ensure that the audit report contains the following elements:
  – A statement that you audited the provider's Medicare cost report;
  – A statement that the audit was conducted in accordance with GAS;
  – If the report relates to a provider's Medicare cost report, a statement that those standards require the contractor to plan and perform the audit to obtain reasonable assurance about whether the cost report reflects payment amounts
and financial data in accordance with Medicare laws, regulations, and instructions;

− A statement that the Medicare provider is responsible for compliance with Medicare laws, regulations, and instructions.
− Reference the Medicare cost report audit adjustment report. (See §70.4 of this chapter.)

• Refer to areas selected for audit. Any areas selected for in-house or field audit must be listed.

• Include a listing of the applicable internal control policy and procedure categories, as they affect Medicare payment.

Use Exhibit VII in §170 of this chapter as an example of a Medicare audit report, including the report on the consideration of the internal control structure of the provider.

Edit the audit report to fit the particular circumstances of the audit. For example, if you decided that a review of a provider's system of internal control was not applicable, use one of the alternative paragraphs to explain the basis for this decision. In this situation, the language pertaining to a review of internal control would not be applicable and should not be included in your audit report to the provider. Conversely, if you did perform a review of internal control, do not use the alternative paragraphs. Instead, use the language pertaining to the review of internal control system as appropriate.

130 – Provider Permanent File
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

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.

Depending on the provider type and payment methodology, the following are examples of the information that can be maintained in the permanent reference file.

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 Provider Reimbursement Manual, Part I, Chapter 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.
# Exhibit 1 – Summary of UDR Issues

**UNIFORM DESK REVIEW**  
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

**Summary of Issues**  
(Instructions are contained in the Financial Management Manual, Chapter 8, §20.2.F)

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<th>Reference (See Instr.)</th>
<th>Description</th>
<th>Units/$</th>
<th>No Further Action</th>
<th>Audit Deferred</th>
<th>Scoped for Audit</th>
<th>Adjusted for Settlement</th>
<th>Comments</th>
<th>UDR Resolution or Audit W/P Ref.</th>
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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 twelve (12) weeks following the pre-exit conference. 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 II b – Audit Confirmation Letter – In-House Audit
(Rev. 107, Issued: 09-22-06; Effective: 10-01-06; Implementation: 10-02-06)

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 an in-house 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 a telephone entrance conference to be held (the date and time of the telephone conference). We ask that at least the chief financial officer, the person who prepared the cost report and anyone designated as your liaison for the audit participates during the entrance conference. In addition, we ask that the information listed on the attached schedule be sent to the contractor’s location one week prior to (the date of the telephone entrance conference).

If you need to reschedule the entrance conference, please notify us 2 weeks prior to scheduled audit, and we will attempt to accommodate your request. Again all documentation found on the attached list must be sent one week prior to the telephone 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 sent to you during the course of the audit. You may request the work papers that support the adjustments at any time. A pre-exit telephone conference will be tentatively planned to be on MMDDYYYY. During this telephone conference, 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 a telephone exit conference within twelve (12) weeks following the pre-exit conference. 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 in-house 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 in-house audits and more accurate settlements of cost reports.

If you wish to discuss this matter please contact ______________ at________________.

Sincerely,

Signature, Title

Enclosures

cc: