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CHANGE REQUEST 2902

I. SUMMARY OF CHANGES: This transmittal includes a complete revision and reordering of the instructions found in chapters 8, 9 and 10 of the Medicare Financial Management Manual. This revision includes new instructions and also consolidates the three current chapters found in the Financial Management Manual to just two chapters. The revision is intended to be a reorganization and compilation of all contractor procedures for provider audits. *One major revision in Chapter 8 that is being communicated in this transmittal is the elimination of the "focused review" category of audits. However, contractors may continue to perform focused reviews through fiscal year (FY) 2004.*

NEW/REVISED MATERIAL - EFFECTIVE DATE: January 1, 2004
***IMPLEMENTATION DATE: January 5, 2004**

Disclaimer: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged.

II. CHANGES IN MANUAL INSTRUCTIONS:
(R = REVISED, N = NEW, D = DELETED)

R/N/D	CHAPTER/SECTION/SUBSECTION/TITLE
R	8/ Introduction
R	8/ 10/ Receipt and Acceptance of Cost Reports
R	8/ 10.1/ Contractor's Responsibility Prior to Submission of Cost Reports
R	8/ 10.2/ Contractor's Responsibility If the Provider Fails to File a Cost Report Timely or the Cost Report is Rejected
R	8/10.3/ Acceptance of Medicare Cost Report
R	8/ 10.4/ Submission of Cost Report Data to CMS
R	8/ 10.5/ Initial/Tentative Retroactive Adjustments (a.k.a. Tentative Settlements)
R	8/ 20/ Desk Reviews
R	8/ 20.1/ Definition

R	8/ 20.2/ Components of the Uniform Desk Review (UDR)
R	8/ 20.3/ Desk Review Exceptions Resolution Process
R	8/ 20.4/ Wage Index Review
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R	8/ 40/ Field Audit Planning and Management (Global Scoping)
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***Medicare contractors only**

Medicare Financial Management Manual
Chapter 8 – Contractor Procedures for Provider Audits

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Introduction
(Rev. 27, 12-19-03)

This chapter explains the procedures to be applied/implemented by contractors to ensure that acceptable cost reports are submitted by providers in a timely manner, that they are appropriately reviewed, and are properly settled.

10 – Receipt and Acceptance of Cost Reports
(Rev. 27, 12-19-03)

10.1 – Contractor's Responsibility Prior to Submission of Cost Reports
(Rev. 27, 12-19-03)

In accordance with the Provider Reimbursement Manual, Part II (PRM-II), §104ff, providers that continue to participate in the Program and are required to submit a cost report must do so within 5 months of their cost reporting fiscal year end or 30 days after receipt of valid Provider Statistical and Reimbursement (PS&R) reports from the contractor, whichever date is later. Exceptions to this due date for "no Medicare utilization" cost reports are addressed in PRM-II, §110.A.

If the provider fails to file the cost report by the last day of the fourth month following the close of its cost reporting period, the contractor is required to send a reminder letter to the provider to help ensure that the cost report will be filed timely. (This letter may be sent sooner if the contractor wishes to send it at the time it sends the PS&R summary reports.) The reminder letter informs the provider of the due date for filing the cost report and the penalty for not filing the cost report timely. Furthermore, the reminder letter should include a statement that if the cost report cannot be submitted by the due date, the provider may request a reduced payment suspension rate of 50 percent during a grace period of 60 days. The reminder letter should specify that this request should be submitted before the due date of the cost report.

If the contractor receives a request for a reduction in the rate of suspension either because the cost report will not be filed timely or because the submitted cost report was rejected and believes that the request should be approved, the contractor should recommend to the Regional Office (RO) that the provider's suspension rate be reduced to 50 percent (or a different rate if appropriate because of unique circumstances) for a 60-day grace period. The contractor should maintain a copy of the RO's approval/disapproval of this request in the provider's file.

PRM-II, §104.A.3 specifies that the provider must receive the PS&R report on or before the 120th day following the close of a provider's cost reporting period. Therefore, the contractor is required to furnish each provider with a copy of the year-to-date summary PS&R reports by the 120th day after the end of the provider's cost reporting period. These PS&R reports (by type) should split the summary data into appropriate portions of the provider's cost reporting period as dictated by the Medicare reimbursement policies (e.g., federal payments need to be split as specified in PRM-II, §3630 in order to calculate the indirect medical education and disproportionate share hospital payments). A split may also be necessary because of the provider's unique situation. Having the split PS&R reports will enable the provider to file the cost report accurately. (See Chapter 9 of this manual for detailed description of the PS&R reports.)

If a provider requests detailed PS&R data (e.g., payment reconciliation report) to reconcile their records with your records, furnish an annual detailed PS&R reports at no cost to the provider. If a provider requests interim (other than annual) detailed PS&R report data, provide the detailed data at intervals requested by the provider as long as they are reasonable. You may charge the provider a fee for this extra service. The fee should be reasonably related to costs you incur for the added service and be commensurate with your charge to all other providers for similar data.

Furnish the PS&R reports on electronic media, when cost effective, or on paper. The provider is expected to make reasonable efforts to process electronic media.

10.2 – Contractor's Responsibility If the Provider Fails to File a Cost Report Timely or the Cost Report is Rejected
(Rev. 27, 12-19-03)

If the provider fails to submit a cost report timely (see PRM-II, §104.A.4 and Chapter 3, §30.1.A of this manual,) or if the cost report is rejected because it is not acceptable, the contractor should suspend payments in accordance with 42 CFR 405.371. (See PRM-II, §130.4 for explanation of a grace period for suspension of payments applicable to cost reports that were filed early but were subsequently rejected.) Terminated providers should immediately have 100 percent of their payments suspended for failure to file a cost report in a timely manner. If other than a terminated provider submitted a request for reduction in the rate of suspension (see §10.1 of this chapter) and it was approved, the contractor should suspend 50 percent (or a percentage approved by the RO) of the provider's payment for the first 60 days that the cost report is late. If an acceptable cost report has not been filed on the 61st day after the due date, the contractor should change the rate of suspension to 100 percent. If the provider did not request a reduction in the rate of suspension, or the contractor did not concur with the request for a reduced suspension rate, then 100 percent of the provider's payments should be suspended if an acceptable cost report is not filed by the due date.

If system limitations preclude you from suspending payments based on a reduced percentage rate, base the suspension on the dollar amount that results from applying the

applicable percentage rate to the average payment for the six (6) months prior to the suspension.

Prepare a demand letter(s) for all previous payments in accordance with Chapter 4, §§10 and 20 of this manual. Payment due dates and interest assessments are still based on the due date of the cost report.

10.3 – Acceptance of Medicare Cost Report
(Rev. 27, 12-19-03)

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 the 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.

<u>For all other providers:</u>

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. <u>However, failure to supply any or all of those items is not a basis for rejection of the cost report.</u> These items, which are also detailed in PRM-II, Section 140 are:

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.*

Since the provider's failure to submit any of the documentation related to items 1-7 above does not render the cost report unacceptable, accept the cost report even if some significant documentation related to those items is missing. However, if you decide to request any of the significant missing documentation, you must do so in a way that will allow you to give the provider at least 15 days to submit it, and still be able to complete the tentative settlement within the prescribed time after receipt of an acceptable cost report. Should the provider fail to submit the requested items, you may adjust the tentative settlement where you deem appropriate.

10.4 – Submission of Cost Report Data to CMS
(Rev. 27, 12-19-03)

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 60 days of the receipt of the cost report.

- *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.

10.5 – Initial/Tentative Retroactive Adjustments (a.k.a. Tentative Settlements)
(Rev. 27, 12-19-03)

Section 42 CFR 413.64 and the Provider Reimbursement Manual, Part 1 (PRM-I), §2408.2, stipulate that an initial/tentative retroactive adjustment must be made as quickly as possible after the receipt of a cost report from the provider. Therefore, make such adjustments within 60 days of the acceptance of the provider's cost report. Prompt initial/tentative retroactive adjustments are essential to ensure proper cash flow to providers. Reducing or delaying tentative settlements until a final determination could jeopardize the financial viability of some providers.

You are not required to make initial/tentative retroactive adjustments where one of the conditions listed in §2408.2 of PRM-I applies. You are also not required to make initial/tentative retroactive adjustments for Skilled Nursing Facilities (SNFs) and Home Health Agencies (HHAs) when the provider did not receive Periodic Interim Payments (PIP) or other interim payments and the cost report does not include a claim for any

reimbursement (e.g., bad debts, drug expenses) paid outside of the PPS system. However, you must complete initial/tentative retroactive adjustments of SNF and HHA cost reports when a portion of the provider's payment is based on amounts determined through the cost report methodology (e.g., bad debts, drug expenses) or when the provider received PIP or non-PIP interim payments.

For the purpose of initial/tentative retroactive adjustment, accept costs as reported. However, to avoid creating an overpayment, reduce the payment by any amounts attributable to obvious errors or inconsistencies in the cost report. Also give consideration to amounts owed the program by the provider (e.g., possible adjustments for prior periods and current period for unresolved issues, unrecovered overpayment). If the current year's tentative settlement results in an underpayment and the provider has existing Medicare overpayments, follow the instructions in Chapter 3 of this manual. In instances where a provider is in bankruptcy or is part of bankruptcy proceedings, bankruptcy procedures will supersede these instructions.

Cost-to-charge ratios (CCRs) are used in determining outlier payments, payments for pass-through devices, and monthly interim transitional corridor payments under the outpatient prospective payment system (OPPS). CCRs are also used to determine payments for extraordinarily high cost cases (cost outliers) under the acute care hospitals inpatient and long term care hospitals prospective payment systems (IPPS and LTCH PPS, respectively). You are required to update the CCRs for providers reimbursed under the OPPS, IPPS, and LTCH PPS to reflect cost and charge information from a provider's most recent cost reporting period, whether tentatively settled or final settled. Therefore, immediately after completion of the tentative settlement, calculate the updated CCRs in a manner described below and input them into the Outpatient Provider Specific File (OPSF) and Provider Specific File (PSF).

- *If you made adjustments during the tentative settlement for prior year audit adjustments or other changes and these adjustments have an impact of more than 20% (plus/minus) on the CCRs from the "as filed" cost report, calculate the updated CCRs using the tentative settlement data.*

- *If the tentative settlement adjustments have an impact of 20% or less on the CCRs from the "as filed" cost report, or if no adjustments to the tentative settlement were made, calculate the updated CCRs using the hospital's "as filed" cost report.*

20 – Desk Reviews
(Rev. 27, 12-19-03)

20.1 – Definition
(Rev. 27, 12-19-03)

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 a field audit or whether a 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 field audit). If a decision is made to field 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. 27, 12-19-03)

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 all other supporting documentation, and that the electronic cost report passes all Level I edits.

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 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 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 field 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., 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. 27, 12-19-03)

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 10 days, 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.*

20.4 – Wage Index Review
(Rev. 27, 12-19-03)

Section 1886 (d)(s)(E) of the Social Security Act, "Adjusting for Different Area Wage Levels," requires the Secretary to adjust the proportion of hospital costs attributable to wages and wage-related costs for area differences in hospital wage levels. This adjustment factor, the wage index, reflects the relative hospital wage level in the geographic area of the hospital compared to the national average hospital wage level.

Wage Index reviews must be completed on all cost reports for short-term acute inpatient prospective payment system (IPPS) hospitals and hospitals that would otherwise be subject to IPPS if they did not have a waiver. Use the latest wage index desk review program released by CMS prior to the due date of the yearly wage index reviews.

Wage index periods follow the federal fiscal period of October 1 – September 30. If a hospital has more than one cost report beginning during the wage index period (for example, a hospital has two short period cost reports beginning on or after October 1, through September 30 of a given year), conduct a desk review on only one of the reporting periods. Select the longest period. If there is more than one period of that length, select the latest period.

30 – Field Audits
(Rev. 27, 12-19-03)

30.1 – Definition of Field Audit
(Rev. 27, 12-19-03)

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 §60.14.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 Audit
(Rev. 27, 12-19-03)

Medicare field audits are conducted in order to: (1) provide reasonable assurance that program payments are based on Medicare reimbursement principles, (2) discover any instances of fraud and abuse, and (3) 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 – Field Audit Planning and Management (Global Scoping)
(Rev. 27, 12-19-03)

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.

40.1 – Cost Reports and Auditing of Multiple Provider Institution (Rev. 27, 12-19-03)

Where an institution certified as a certain type (e.g., hospital, SNF, HHA) has a distinct unit certified as another provider type (e.g., a hospital has a SNF, HHA, or a unit excluded from inpatient prospective payment system), each such distinct unit (a.k.a. subprovider) is, in effect, another department of the provider. Cost finding in such an institution involves allocation of the institution's costs between the main provider and subproviders (e.g., between the hospital and the SNF, HHA, or excluded unit). Thus, provider complexes with subproviders must file one cost report on the CMS cost reporting forms designated for the main provider (e.g., Form CMS-2552 for hospitals). Separate cost reports may not be filed for the provider-based components (subproviders).

Therefore, in your audit plan, consider the audit of a multiple provider institution as one workload unit but, as appropriate, include audit procedures to review the provider-based component(s).

40.2 – Audit Priority Considerations (Rev. 27, 12-19-03)

One or more of the following audit priority considerations may enter into the process of formulating your audit plan.

A – Significance of Total Medicare Program Payments

In a PPS environment, direct specific attention to the following reimbursement areas or issues.

- *Bad debts.*
- *Graduate medical education (GME).*
- *Indirect medical education (IME).*
- *Organ acquisition costs.*
- *Disproportionate share hospital (DSH) payments.*
- *Units excluded from inpatient PPS.*
- *Allocations between PPS providers and cost-reimbursed subproviders.*
- *Nursing/Allied Health passthrough payments.*
- *Outlier payments.*
- *Transitional corridor payments under the outpatient PPS (where applicable).*

B – Types of Providers

Special attention may be required for certain types of providers because of known or anticipated problems or circumstances. Consider the following in your audit plan.

- *New providers.*
- *Providers reimbursed on a cost basis (e.g., critical access hospitals, cancer hospitals).*
- *End Stage Renal Disease Facilities need to be audited in accordance with the Balanced Budget Act requirements.*
- *Providers receiving significant non-PPS payments.*
- *Providers that were not audited recently.*

C – Conditions and Occurrences at the Provider

- *Change of ownership, termination, or change of provider type (e.g., critical access hospitals).*

- *Cost report filed late without a satisfactory explanation.*

- *Fraud and abuse investigations as directed by the Office of Inspector General (OIG) or Department of Justice (DOJ).*

50 – Scoping/Planning of Individual Field Audits (Rev. 27, 12-19-03)

50.1 – Establishing the Objective/Scope of the Field Audit (Rev. 27, 12-19-03)

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 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.

50.2 – Tailoring of the Audit Program
(Rev. 27, 12-19-03)

An audit program provides the audit procedures that auditors must follow to achieve the audit objectives. Prepare a specific audit program for each 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 Audit Process
(Rev. 27, 12-19-03)

60.1 – Audit Confirmation Letter (a.k.a. Engagement Letter)
(Rev. 27, 12-19-03)

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 agenda – Exhibit V in §170 of this chapter.)*

- *A tentative exit conference date set approximately 3 to 4 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. 27, 12-19-03)

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, schedule the pre-exit conference, and establish a tentative exit conference date;*

- *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. 27, 12-19-03)

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 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 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.

60.4 – Reliance on Work Done by Other Auditors

(Rev. 27, 12-19-03)

A – General Guidelines

Medicare audits are generally limited to tests of compliance with Medicare reimbursement policies and procedures. In performing these audits, you generally rely on the financial statements prepared by independent auditors. This includes the independent auditors' review of providers' accounting systems.

To the extent that an independent auditor issued an unqualified opinion on a provider's financial statement and has not identified any material weaknesses in the provider's internal control structure, rely on the provider's system of accounting, including related computer systems. This does not include reliance on records or systems that are maintained solely for purposes of completing a Medicare cost report. As mentioned in §60.3 of this chapter, you may wish to perform substantive tests of the records maintained solely for Medicare reimbursement purposes.

If an independent auditor issued a qualified opinion, an adverse opinion, or has identified material weaknesses in the internal control structure, evaluate the effect of the auditor's actions on your audit objective. If there has been no audit by an independent auditor, consider the audit resources available, the audit risk, and the audit objectives in deciding if there is a need to review the accounting systems. (See §60.3 of this chapter.)

Furthermore, you may rely on work of other auditors (i.e., provider's internal or independent auditors and audit organizations established by the Federal and State Governments for programs other than Medicare) in situations where the scope of this work relates to issues that you scoped for the Medicare field audit. However, in this situation, you must still satisfy yourself with the quality of the other auditors' work by performing appropriate tests or by other acceptable methods.

B – Obtaining Management Letter and/or Documentation Prepared by Provider's Independent Auditors

If you determine that it is necessary to gain an understanding of a provider's internal control structure or any other aspect of the accounting system (see §60.3.B of this chapter), you may request that the provider furnish you with the management letter or other documentation relevant to the Medicare audit that was prepared by an independent auditor or certified public accounting (CPA) firm

Under §§1815(a) and 1833(e) of the Social Security Act, you or CMS may review any documentation it deems necessary to determine whether payment for reasonable cost to a particular provider is appropriate. The implementing regulations at 42 CFR 413.20 and 413.24 explain this further. 42 CFR 413.20(e) specifically allows suspension of payment if the intermediary determines that the provider does not maintain adequate records for the determination of reasonable costs. Additionally, 42 CFR 405.372(a)(2) provides for suspension of payment for failure to provide specifically requested information. However, when the documentation is maintained by an independent auditor or certified public accounting (CPA) firm rather than by a provider, you or CMS must insist that the provider obtain the information from that audit entity. Since the law and regulations are directed to providers, not their auditors or CPA firms, CMS requires the provider to have the independent auditor release the documentation to CMS or the contractor. The independent auditor is at a minimum a de facto agent of the provider and should comply with the request. If the provider is not able to produce the documentation from the independent auditor/CPA firm, you may disallow all the provider's cost/reimbursement associated with the cost report(s) under review or at least suspend payment until the documentation is provided if an appropriate determination of payment cannot be made without the documentation. CMS has limited recourse against the independent auditor or CPA firm if it refuses to comply.

Keep independent auditors' management letters or other documentation obtained from a provider or the independent auditors in a secure place. Disclose the contents only to those directly involved with the audit.

60.5 – Coordination of Activities During the Field Audit
(Rev. 27, 12-19-03)

In order to ensure that the 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 meeting regularly with the provider liaison to handle the following:

- *Requests for documentation that was not mentioned in the audit confirmation letter and was 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.*

60.6 – Designing Tests/Sampling
(Rev. 27, 12-19-03)

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 to 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.

60.7 – Evidence
(Rev. 27, 12-19-03)

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 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.)

60.8– Working Papers
(Rev. 27, 12-19-03)

AICPA Standards and GAS require that "a record of the auditors' work should be retained in the form of working papers." An additional working paper standard requires that "working papers should contain sufficient information to enable an experienced auditor having no previous connection with the audit to ascertain from them the evidence that supports the auditors' significant conclusions and judgments."

A – Definition

Working papers contain evidence accumulated throughout the audit to support the work performed, the results of the audit, including adjustments made, and the judgment of the auditors. They must stand on their own without the need for supplemental explanation or documentation.

Working papers are the records kept by the auditor of the procedures applied, the tests performed, the information obtained, and the pertinent conclusions (findings, no findings, dollar adjustments) established during the audit. Examples of working papers are audit programs, analyses, memoranda, letters of confirmation and representation, abstracts of provider documents, and schedules or commentaries prepared or obtained by the auditor. Working papers may be in the form of data stored on tapes, film, or other media.

Prepare and maintain working papers, the form and content of which should be designed to meet the circumstances of a particular audit. The information contained in working papers constitutes the principal record of the work that the auditor has done and the conclusions that the auditor reached concerning significant matters.

B – General Content of Working Papers

Working papers should ordinarily include documentation showing that:

- *The work has been adequately planned and supervised. This includes consideration of the audit requirements of Medicare and any other payers, which are part of a common audit with Medicare.*

- *The audit evidence obtained, the auditing procedures applied, and the testing performed have provided sufficient, competent evidential matter to support the auditor's conclusions.*

C – Format of Working Papers

Ensure that the working papers are prepared using the following standards.

Start each individual working paper with the basic mechanical foundation containing:

- *Provider name, number, and cost reporting period.*
- *Preparer's signature or initials.*
- *Date the work was performed.*
- *Proper heading, giving basic content of the working paper.*
- *Working paper number or reference.*
- *Purpose–A brief description of the work to be done on the working paper and the objective to be achieved (e.g., a comparison of the contractor's PS&R with the as-filed settlement data to validate the provider's claimed Medicare statistics).*
- *Source of Information–This informs the reviewer where the information used on the working paper was obtained. The source can be a description of the particulars, e.g., Medical Records Admission Register, or it can be in the form of cross-referencing to the cost report, financial statements, or other working papers. Cross-referencing is especially important because it enables the reviewer to see at a glance exactly where an amount, number etc. comes from. Copies, or if appropriate samples, of the information/ documents examined must be retained in the working papers.*
- *Scope of Work–The stated scope of work should enable a reviewer to determine if an adequate test was performed to meet the scope of the audit purpose.*
- *Explanation of Tick Marks– Use tick marks to explain and cross-reference the work performed.*
- *Conclusion–When a working paper is complete, the contractor shall state conclusions covering the results of the audit activity.*
  - *EXAMPLE: No exceptions were noted in the test; therefore, the as-filed number of full time equivalent (FTE) residents used for GME payment is accepted.*
  - *EXAMPLE: Exceptions were noted in the number of FTE residents used for GME payment. An adjustment is proposed to correct the as-filed GME FTE statistic.*

Furthermore, the working papers should:

- *Be legible, complete, and accurate in order to provide proper support for findings,*

judgments, conclusions, and to document the nature and scope of the work conducted

- *Contain sufficient information so that supplementary oral explanations are not required;*

- *Include summaries and lead schedules, as appropriate;*

- *Contain adequate indexing and cross-referencing to the audit program, lead summaries, and adjustment report. (Each audit step that is initialed on the audit program should contain a reference to the "specific" working paper on which this step was addressed. It is not acceptable to just reference the general working paper series for an area under each audit step for that area. For example, include a reference to W/P 13-1(a) instead of W/P 13 series. Also, if you reference a specific working paper under the first audit step pertaining to an area/issue, do not draw a vertical line from that reference through all other audit steps for that area unless all the audit work for all those audit steps was actually detailed on that working paper.*

- *Restrict information to matters that are materially important and relevant to the objectives of the audit;*

- *Contain evidence of supervisory review of the work including initials.*

- *Include an index to working papers for ease of reference.*

- *Include the audit program. However, do not retain pages of a standard audit program that are not applicable to the audit. If in the audit program for a specific provider you retain audit steps from the standard audit program that were not scoped, mark them "N/A" instead of leaving them unmarked.*

D – Ownership and Custody of the Working Papers

Working papers are the property of the auditor. The auditor's rights of ownership, however, are subject to ethical limitations relating to the confidential relationship with providers.

Adopt reasonable procedures for safe custody of working papers in the field as well as in your office in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and retain them for a sufficient period of time to meet the needs of your operation and to satisfy legal requirements of record retention.

When requested, send original working papers to the appropriate CMS component or CMS' designated agent for review.

60.9 – Documentation Standards
(Rev. 27, 12-19-03)

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 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 and field audit.

60.10 – Pre-Exit Conference
(Rev. 27, 12-19-03)

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 3-4 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. 27, 12-19-03)

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 10-days, 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).

60.12 – Exit Conference
(Rev. 27, 12-19-03)

Each provider is entitled to an exit conference. If the provider wishes to waive a formal exit conference, it must notify the audit and reimbursement manager of this decision in writing shortly after the pre-exit conference.

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.

60.13 – Supervision During the Audit Process (Rev. 27, 12-19-03)

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 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 – Reporting Standards
(Rev. 27, 12-19-03)

70.1 – Content and Structure of the Medicare Cost Report Audit Report
(Rev. 27, 12-19-03)

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 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.

70.2 – Form of Report if Medicare Cost Report was not Audited
(Rev. 27, 12-19-03)

If the Medicare cost report has been settled without audit, issue a report as part of the cost report settlement. Use Exhibit VIII in §170 of this chapter as a sample.

70.3 – Reporting of Indications of Illegal Acts
(Rev. 27, 12-19-03)

Illegal acts would consist of fraud or abuse against the Medicare program. Do not issue a report for any audit where illegal acts or indications of illegal acts are discovered and a fraud or abuse referral is made to the CMS regional office. Office of the Inspector General (OIG) will notify you in writing of the content of the report to be used. However, issue a report in situations where for several years you have made recurring adjustments, notified the provider, and referred the situation to OIG. (See §140.2 of this chapter.)

70.4 – Audit Adjustment Report
(Rev. 27, 12-19-03)

The audit adjustment report is a complete listing, in a logical order of presentation, of audit adjustments arising from the contractor's examination of the cost report. It contains the description of each audit adjustment in sufficient detail to explain the provider's noncompliance, the adjustment amount, and the Medicare cost report reference where the adjustment is to be applied to the revised cost report.

Ensure that the audit adjustment report is prepared in the format of the sample report shown in Exhibit VI in §170 of this chapter.

Where no adjustments were made to the cost report as originally submitted by the provider, you may include the adjustment forms marked "not applicable" or reflecting "0" amounts. However, these forms may be omitted if the notes to the cost report indicate that no adjustments were made.

70.5 – Assembling the Medicare Cost Report and All Related Attachments (Rev. 27, 12-19-03)

Assemble the applicable documents relating to the Medicare cost report and Medicare audit report(s) in the following order:

- *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 – Standards for Performing Medicare Audits (Rev. 27, 12-19-03)

In performing a Medicare audit, comply with the standards outlined in Chapter 3 of the Government Auditing Standards (GAS) entitled "General Standards". The American Institute of Certified Public Accountants (AICPA) Statements on auditing standards have been adopted and incorporated as GAS requirements.

These standards apply to all audit organizations, both government and nongovernmental (e.g., public accounting firms), that conduct government audits, unless specifically excluded. The general standards applicable to Medicare audits are:

- *Qualifications;*
- *Independence;*

- *Due Professional Care; and*
- *Quality Control.*

80.1 – Qualifications
(Rev. 27, 12-19-03)

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 shall 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.*

80.2 – Independence

(Rev. 27, 12-19-03)

The second general standard for government auditing is:

"In all matters relating to the audit work, the audit organization and the individual auditors, whether government or public, should be free from personal and external impairments to independence, should be organizationally independent, and should maintain an independent attitude and appearance."

Maintain independence so that opinions, conclusions, judgments, and recommendations are impartial and viewed as impartial by knowledgeable third parties.

Consider the three general classes of impairments to independence:

- *Personal – There are circumstances in which auditors are not impartial or are not perceived to be impartial.*

- *External – Factors external to the contractor may restrict the audit or interfere with an auditor's ability to form independent and objective opinions and conclusions.*

- *Organizational – A government auditors' independence is affected by their place within the structure of the government entity to which they are assigned and also by whether they are auditing internally or auditing other entities. Since the contractor audits outside the government entity to which it is assigned (i.e., CMS is not related to the providers being audited), this is generally not a concern for a Medicare audit, unless you are an insurance company that in its private line of business makes payment for health care benefits to providers of service that are related to or are based on Medicare payment formulas or payment methods.*

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

See Exhibit IX in §170 of this chapter for a sample of the Personal Impairment Statement to be completed by each individual involved in the desk review, field audit, and settlement activities to ensure that he/she is free of personal impairments. This statement can be completed by each individual on an annual basis and be updated during the year if circumstances that need to be disclosed arise.

80.3 – Due Professional Care
(Rev. 27, 12-19-03)

The third general standard for government auditing is:

"Due professional care should be used in conducting the audit and preparing related reports."

This standard places responsibility on the contractor and on its auditors to follow all applicable standards in conducting Medicare audits.

Exercising due professional care means using sound professional judgment in establishing the scope, selecting the methodology, and choosing tests and procedures for the audit. Follow the same judgment in conducting the tests and procedures and in evaluating and reporting on the audit results.

A – Materiality and Significance

In planning the audit, selecting the methodology, and designing audit tests and procedures, consider materiality and significance. Communicate to your audit staff your quantifiable parameters for materiality and significance.

B – Relying on the Work of Others

(See §60.4 of this chapter for discussion on reliance on the work of other auditors.)

C – Audit Follow-Up

Due professional care also includes follow-up on findings and recommendations from previous audits that could have an impact on the current audit objectives. Determine whether prompt and appropriate actions have been taken on findings and recommendations by provider officials or other appropriate organizations. Pay special attention to how the provider implemented recommendations you may have given in a prior year regarding nonallowable costs or items. (See §140ff of this chapter.)

D – Audit Scope Impairments

For all audits, auditors should consider whether audit scope impairments adversely affect their ability to conduct the audit in accordance with the GAS standards. Audit scope impairments are factors external to the audit organization that can restrict the auditor's ability to render objective opinions and conclusions.

80.4 – Internal Quality Control
(Rev. 27, 12-19-03)

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) <u>or using other review mechanisms</u>. 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.*

E – 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 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. 27, 12-19-03)

CMS expects that you settle 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 a Notice of Program Reimbursement (NPR) and a final adjustment report to the provider within 60 days of the exit conference.

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 that is dated no earlier than 90 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 that is dated no earlier than 90 days prior to the NPR date. (See also Chapter 9, §20.1 of this manual.)

90.1 – Submission of Settled Cost Report Data to CMS
(Rev. 27, 12-19-03)

Within 30 days after issuance of the NPR to the provider, submit to CMS an extract of the following Medicare cost reports in accordance with the Healthcare Cost Report Information System (HCRIS) specifications:

- *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.

HCRIS requires only one submission of the cost report data for "Low" or "No Medicare Utilization" providers. This submission is due within 30 days of the settlement (either with or without audit) of the cost report.

The cost report data is contained in the HCRIS database at CMS and is updated on a quarterly basis. This database is available to all users authorized at CMS. The cost report data files in the HCRIS database are also available to the public on the CMS Web site.

100 – Cost Report Reopenings
(Rev. 27, 12-19-03)

Instructions that describe the circumstances under which the final determination on a cost report can be reopened are contained in 42 CFR 405.1885 and PRM-1, Sections 2931 through 2932. In accordance with these instructions, you may reopen a cost report if you receive a written request to reopen from the provider within 3 years of the date that the Notice of Amount of Program Reimbursement (NPR) was issued. You may also reopen a cost report within the 3-year reopening period based on your own motion or at the request of CMS. However, if fraud or similar fault is involved, you can reopen the cost report at any time.

If a provider submits a written reopening request to you before the 3-year reopening period expires, you must apply the provisions of PRM-1, §2931.2 when making a decision whether the provider's request warrants a reopening. You must issue a reopening notice or a denial of reopening to the provider in writing.

A single letter may be used as a notice of reopening of some issues and a denial of other issues. However, ensure that all issues that you intend to reopen are listed in the written reopening notice. Where you deny the provider's reopening request, include in the written notification to the provider detailed reasons for the rejection. Such reasons could include:

- *Untimely request, with an indication of the dates and documents being used in the determination.*

- *Incomplete request, with an explanation of why it was determined to be incomplete.*

- *Criteria for reopening not met, with an explanation of why the criteria were not met.*

Where you grant a provider's reopening request and discover that additional information is still needed, whether before or after the 3-year reopening period expires, send a written notice to the provider requesting that the needed information be submitted within a specified time. In normal circumstances the provider should submit the documentation within 60 days of your request. If the provider fails to submit the requested information, you may withdraw the notice of reopening and deny the reopening.

You must also send the provider a written reopening notice detailing the issues when reopening the cost report on your own motion or at CMS' request. If you reopen the cost report and plan to resolve the issues without a field audit but need additional information, send a written notice to the provider requesting that the needed information be submitted within a specified time (generally within 60 days of the request). If the provider fails to submit the requested information, adjust the cost report accordingly. If you determine that a field audit is necessary to resolve the reopening issues, follow the instructions in §§60.1, 60.10, 60.11, and 60.12 pertaining to information requests.

Whenever you issue a NPR for a provider that is part of a chain before the home office cost statement is finalized, include a reopening letter with the NPR specifying that the amount of program reimbursement may be changed upon receipt of finalized home office cost statement. However, do not issue such a reopening notice to a provider that is paid entirely under PPS or if the amount of home office cost claimed in the cost report is immaterial. When the home office cost statement is finalized, close the reopening by issuing either a revised NPR or a notice that the reopening is being closed.

If issues outside the scope of the reopening notice are discovered during the course of the reopening process and reaudit, you may address such issues only if the provider submits another reopening request before the expiration of the 3-year reopening period or you issue another notice of reopening within the 3-year reopening period.

Issue a revised NPR for all reopened cost reports within 180 days of receipt of all information/documentation necessary to resolve the reopening issues. Discuss with the RO any situations where unforeseen circumstances prevent you from meeting these expectations.

Furthermore, you are required to submit HCRIS extracts to CMS each and every time that you issue a revised NPR following a reopening of a cost report. These submissions are due within 30 days after the issuance of the revised NPR. (See §§10.4 and 90.1 for details of the type of facility cost reports that are to be submitted.)

110 – Audit Responsibility When Provider Changes Contractors (Rev. 27, 12-19-03)

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, forward to the incoming contractor a copy of the last settled cost report that you are responsible for together with all the working papers (including the permanent file and correspondence files) as soon as possible. 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. 27, 12-19-03)

Where a provider is related to a chain organization within the meaning of 42 CFR 413.17, 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.

120.1 – Audit Responsibility for Home Office Costs of Chain Organizations
(Rev. 27, 12-19-03)

Ordinarily, the contractor responsible for settlement of the provider's cost report and, if necessary, auditing its records is also responsible for auditing the home office cost

statement to verify the validity of the costs allocated to the provider. However, if more than one contractor services providers that are members of the chain, this could result in duplication of audit expenses and inconvenience to the home office. Therefore, where more than one contractor services the providers of a chain organization, CMS designates the contractor that will be responsible for the audit of home office cost statement.

In making this determination, CMS Central Office (CO) may consult with the relevant regional offices (ROs) and contractors and consider such factors as geographical location of the home office, number of providers serviced by each contractor, total amount of reimbursement to the chain by each contractor and other relevant factors.

When CMS CO determines which contractor will be responsible for the home office audit, it communicates its decision in writing to all the contractors servicing the providers in the chain and relevant ROs. If the contractors servicing the providers in the chain prefer to have a different contractor perform the audit, they may request CMS to assign the audit responsibility to another contractor. CMS notifies the contractors, in writing, of its final decision.

120.2 – Responsible/Designated Contractor's Responsibility if the Home Office Fails to File a Cost Statement
(Rev. 27, 12-19-03)

Home office cost statements that are prepared in accordance with PRM-1, §2150ff are to be submitted either: (1) before the last day of the fifth month following the close of the fiscal year if the home office's fiscal year ends on the last day of the month, or (2) on or before 150 days after the last day of the fiscal year if the home office's fiscal year ends on a day other than the last day of the month. If the chain home office fails to submit a cost statement within that time frame and you are the responsible/designated contractor for the home office, notify the chain home office of its failure to submit a cost statement. If you are the servicing contractor for some of the providers in the chain, issue tentative or revised tentative settlements requiring repayment of the home office costs to those providers whose cost reports contain significant reimbursement for the related home office costs. Also, if applicable, notify all the other contractors servicing the providers in the chain to do the same. The servicing contractors are also required to reduce interim payments to reflect the disallowance of any home office costs if those costs make up a significant portion of the provider's interim payment.

120.3 – Planning/Scoping the Home Office Audit
(Rev. 27, 12-19-03)

The responsibility for completing the desk review and scoping the audit of the home office cost statement rests with the responsible/designated contractor. If more than one contractor services the providers in the chain, the responsible/designated contractor may request any information its auditors need to scope the audit of the home office cost statement from other contractors. However, if you are the responsible/designated

contractor, do not audit a home office cost statement if all the providers in the chain are paid entirely under the prospective payment methodology or the aggregate amount of the related Medicare reimbursement for all the providers in the chain is immaterial. In those situations, you do not have to complete the desk review.

If the home office cost statement is scoped for audit, the other contractors forward to the responsible contractor the requested information and any other information they have related to the providers they service which they consider relevant to the home office audit. This could include aspects of the chain's operations or their experience in their relationship with the chain that the responsible/designated contractor should be aware of, or should consider during the audit.

If some of the records for an individual provider are maintained at the home office (e.g., insurance or loan records), the servicing contractor for that provider may determine during the desk review/scoping process that some of those records need to be audited. Since the responsibility for auditing any provider records maintained at the home office rests with the responsible/designated contractor, the servicing contractor must submit a written request to the responsible/designated contractor to audit those records. The servicing contractor's written request must include: (1) the provider's cost report, (2) completed desk review, (3) specific areas to be audited, and (4) scope of the audit to be performed.

The responsible/designated contractor considers the exceptions identified during the desk review of the home office cost statement, the additional information furnished by other contractors in response to its request, and the servicing contractors' requests for audit of provider records maintained at the home office in determining the scope of the home office audit.

120.4 – Timing and Completion of Home Office Audits
(Rev. 27, 12-19-03)

Home offices of chain organizations are not providers, thus their costs are not directly payable by Medicare. Home office costs are payable only when they are allocated to the providers in the chain and become part of the providers' allowable costs. Since the allocation of home office costs usually affects all providers in the chain, the audit of the home office cost statement should be performed by the responsible/designated contractor as soon as possible after the receipt of the home office cost statement so that the servicing contractors can expeditiously finalize the settlement or reopening of provider cost reports pending the results of the home office audit.

When you as the responsible/designated contractor begin the audit of the home office cost statement, notify all the other contractors that service the providers within the chain and keep them informed of the progress of the audit and any significant developments. Also, notify the servicing contractor(s) if during the audit you identify adjustments that may affect other providers within the chain that are not being audited. After such notification, you may need to expand the scope of the home office audit if a servicing

contractor requests that you audit the issue on site because it is not possible for that contractor to resolve it any other way. In this situation, the servicing contractor should assist you in preparing the expanded audit steps and forward to you any working papers that you may need.

Any issues relating to the determination and allocation of home office costs are to be resolved by the responsible/designated contractor. If you are the responsible/designated contractor, forward the audit results to the other contractors that service providers within the chain prior to the finalization of the audit adjustments. If any of the other servicing contractors do not agree with your interpretation and application of a policy on a certain issue, that contractor may request that you obtain an interpretation from CMS. Where you do request an interpretation of policy from CMS, delay the resolution of the issue/adjustment until you receive a reply from CMS.

120.5 – Distribution of the Audited Home Office Cost Statement and Results of the Audit
(Rev. 27, 12-19-03)

At the completion of its audit, the responsible/designated contractor distributes the audited home office cost statements and the audit adjustment report to all the contractors that service the providers within the chain.

The results of the audit of the home office cost statement are binding upon all the servicing contractors. The servicing contractors rely upon this audit to identify the allowable portion of the home office costs that can be included in their providers' cost reports. They use the audited home office cost statements to make any necessary adjustments to the home office costs claimed by those provider(s) before they make a final settlement of the related cost reports. If at the request of the servicing contractor, you as the responsible/designated contractor audited the provider's records that are maintained at the home office for specific issues outside the general audit of the home office cost statement, forward the following information related to those issues to the servicing contractor.

- *The scope of the audit work performed,*
- *The schedule of audit adjustments with full explanation why they are necessary and their effect on the provider's cost report, and*
- *The results of discussions with home office personnel pertaining to the audit findings.*

All audit adjustments proposed by the responsible/designated contractor pertaining to the audit of provider records maintained at the home office are binding upon the servicing contractor. If the servicing contractor has any questions concerning the audit or its results, it should resolve the issues with the responsible/designated contractor before the settlement of the provider's cost report. However, when a disagreement cannot be

resolved, the servicing contractor may request the responsible contractor to obtain an interpretation from CMS.

The responsible/designated contractor is reimbursed by the servicing contractor for the costs of auditing provider records maintained at the home office and for any assistance in preparing appeal position papers.

120.6 – Standards for Issuance of an Audit Report for a Home Office (Rev. 27, 12-19-03)

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 VI at the end 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.*

120.7 – Audit Responsibility When Responsible/Designated Contractor Changes (Rev. 27, 12-19-03)

Where the contractor responsible for the home office audit changes, the outgoing contractor makes available to the incoming contractor copies of pertinent prior years' statements of home office costs, desk reviews, audit reports and audit adjustments, and any working papers or documentary material pertinent to the current year's audit.

130 – Provider Permanent File (Rev. 27, 12-19-03)

Maintain a current permanent reference file on each provider with pertinent information for use during interim rate reviews, desk reviews, and field audits. The permanent reference files are central files that contain provider information or index the location of

such information maintained elsewhere. Where permanent reference file data is maintained in desk review and/or audit files, extract and retain it when the desk review and/or audit files are purged.

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 – Fraud & Abuse
(Rev. 27, 12-19-03)

140.1 – Definitions
(Rev. 27, 12-19-03)

A – Abuse

An abuse is the administrative violation of agency regulations, which impair the effective and efficient execution of the program. Violations may result in Federal monetary losses or in denial or reduction in lawfully authorized benefits to participants. They do not involve fraud.

B – Fraud

Fraud is obtaining something of value unlawfully, through willful misrepresentation. It embraces theft, embezzlement, false statements, illegal commissions, kickbacks, conspiracies, obtaining contracts through collusive arrangements and similar devices.

The following are examples (not all inclusive) of potential fraud or abuse:

- *Recording of personal expense items as provider costs for patient care.*
- *Arrangements by providers with employees, independent contractors, suppliers and others which appear to be designed primarily to overcharge the program with various devices, e.g., commissions, fee splitting, to siphon off or conceal illegal profits.*
- *A pattern of overutilization of services to inflate charges to increase reimbursement.*
- *Any evidence of payroll entries and disbursements to personnel who provide little or no services to the provider.*
- *Providers' concealment of business activities, which would affect eligibility for, or amount of, program reimbursement, e.g., undisclosed change of ownership or relationship with a supplying organization.*

- *Falsifying provider records in order to appear to meet the conditions of participation.*
- *Charging to the program costs not incurred or which are attributable to nonchargeable services or nonprogram activities.*
- *Billing for supplies or equipment that are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency as to be virtually worthless.*
- *Duplicate billing which appears to be deliberate. This includes billing Medicare twice or billing both Medicare and the beneficiary for the same services.*
- *Deliberately providing or receiving Medicare payments on the account of other than the proper individual.*
- *Persistently and deliberately billing beneficiaries rather than Medicare for covered services.*
- *Soliciting, offering, or receiving a kickback, bribe, or rebate.*
- *An ineffective board of directors and/or audit committee.*
- *Abuse of internal accounting controls by administrative personnel.*
- *Indications of personal financial problems of administrators.*
- *Significant changes in business practices.*
- *Inadequate working capital or lack of flexibility in debt restrictions such as working capital ratios and limitations on additional borrowing.*
- *A complex corporate structure that does not appear to be warranted by the provider's size.*
- *Frequent changes of legal counsel or of key financial officers such as treasurer or controller.*
- *Premature announcement of profit or loss or of future expectations.*
- *Significant fluctuations in material account balances, financial interrelationships, inventory variances, or inventory turnover rates.*
- *Unusually large payments in relation to services rendered by lawyers, consultants, agents, and others.*
- *Difficulty in obtaining audit evidence with respect to unusual or unexplained entries, incomplete or missing documentation, or alterations in documentation or accounts.*
- *Delays in responses or evasive responses by management to audit inquiries.*
- *Deliberately including cost, without disclosing the fact, in the provider cost report that specifically is nonreimbursable under the regulations. This excludes instances where the provider discloses that the cost report is filed under protest and where the protested issues and their reimbursement effect are disclosed.*

140.2 – Contractor Responsibility In Suspected Fraud or Abuse Cases (Rev. 27, 12-19-03)

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 costs 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 costs in the next cost report could result in referral to the U. S. Attorney General for consideration of criminal and/or civil prosecution.

Use the following model language.

On our audit for the period ___________ to _________ certain cost items were disallowed because they were determined by our auditors to be nonallowable items. When we audited your cost report for the period ___________ to _________ we found the following expenses shown as allowable costs, which were disallowed, in the prior period:

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 costs in future cost reports without disclosure as a protested item 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 costs 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 to disallow 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 a cost 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.

150 – Access to Books, Documents, and Records of Provider's Subcontractors
(Rev. 27, 12-19-03)

150.1 – General

(Rev. 27, 12-19-03)

Section 952 of the Omnibus Reconciliation Act of 1980, enacted December 5, 1980, amended §1861(v)(1)(I) of the Social Security Act to require that a contract (if its cost or value over a 12-month period is $10,000 or more) between a provider and a subcontractor must contain a clause allowing the Department of Health and Human Services' (HHS) Secretary and the U.S. Comptroller General (or their representatives) access to the subcontractor's books, documents, and records that are necessary to verify the nature and extent of costs of services furnished under the contract. This clause must be included in the contract in order for the costs of services furnished under the contract to be included as costs for Medicare reimbursement. In addition, the contract must allow access to contracts of a similar nature between subcontractors and related organizations of the subcontractor, and to their books, documents, and records. The authorized representatives of the HHS Secretary are CMS, CMS' Medicare contractors, and the HHS Inspector General. In most instances, a contractor will be the entity requesting access.

This legislation (codified at 42 Code of Federal Regulations, Subpart D, §§420.300-304) applies to contracts entered into or renewed after December 5, 1980; hence, contracts renewed after December 5, 1980 must be amended to include the clause. The clause must provide for access to the subcontractor's contract and books, documents, and records until 4 years have elapsed after the services are furnished under the contract or subcontract.

> ***NOTE:*** *A provider's cost of renegotiation with a subcontractor to include the access clause in their contract, if it is not excessive and can be adequately justified, is an allowable Medicare cost and therefore may be included in the Administrative and General cost center.*

150.2 – Definitions
(Rev. 27, 12-19-03)

A – Books, Documents, and Records

*All writings, recordings, transcriptions, and tapes of any description necessary to verify the nature and extent of the costs of services provided by a subcontractor. (**NOTE:** For the sake of brevity, the term "books, documents, and records" is hereinafter shortened to "books.")*

B – Common Ownership

An individual(s) who possesses significant ownership or equity in the subcontractor and the entity providing the services under the contract.

C – Control

An individual or organization having the power, directly or indirectly, to significantly influence or direct the action or policies of an organization or institution.

D – Provider

A hospital, skilled nursing facility, home health agency, independent renal dialysis facility, hospice, comprehensive outpatient rehabilitation facility, community mental health center, independent rural health clinic, or a distinct unit of any of these providers.

E – Subcontractor

Any entity, including an individual(s), that contracts with a provider to supply a service, either to the provider or directly to a beneficiary, for which Medicare reimburses the provider the cost of the service. This includes organizations related to the subcontractor that have a contract with the subcontractor for which the cost or value is $10,000 or more in a 12-month period.

F – Related to the Subcontractor

A subcontractor that is, to a significant extent, associated or affiliated with, owns (or is owned by), or has control of (or is controlled by), the organization furnishing the services, facilities, or supplies. If a provider contracts for services with a subcontractor, and the subcontractor thereafter contracts with a related organization (which will actually furnish the services), both contracts must contain the access clause if one of the monetary criteria, described in §150.4, is met.

G – Contract for Services

A contract through which a provider obtains the performance of an act(s), as distinguished from supplies or equipment. It includes any contract for both goods and services to the extent the value or cost of the service component is $10,000 or more within a 12-month period.

150.3 – Types of Contracts Covered by Access Provisions
(Rev. 27, 12-19-03)

The access regulation applies to contracts concerning the purchase of services such as:

- *Consultations, management, medical care provided by physician groups or hospital-based physicians (for which Medicare may reimburse providers on a cost basis);*
- *Linen services (rental of linens);*
- *Furnishing of meals (as opposed to the direct purchase of food);*
- *Legal and accounting services;*
- *Provider management and provider management information systems; and*
- *Insurance and leases for buildings and equipment.*

Subcontracts for public utility services at rates established for uniform applicability to the general public are not subject to the regulation because the rates are already a matter of public record and are not negotiable. Similarly, contracts for workers compensation insurance are not subject to the regulation since the rates are non-negotiable and are also a matter of public record. Contracts concerning construction of buildings (including services of architects, painters, and interior decorators) need not contain the access clause; however, if a provider contracts with an interior decorator, painter, or other individual/company to perform service work on an existing building, the contract must contain the access clause. When a provider contracts to purchase a product that includes a warranty of the product in the price, the contract is not subject to the regulation; however, a separately purchased warranty or service-maintenance contract must contain the subject clause.

150.4 – Monetary Criteria
(Rev. 27, 12-19-03)

There are also monetary criteria to be considered in determining if a contract must contain the access clause. If a contract is subject to the regulation as described in the preceding paragraph and one of the following criteria is met, the clause must be included in the contract:

- *Any contract for services for 12 months or less that is valued at $10,000 or more (e.g., a $12,000 contract for services that are completed in 2 months);*
- *Any series of contracts with a subcontractor for a service(s) that total $10,000 or more over a consecutive 12-month period (e.g., two contracts for 6 months each that are valued at $8,000 each, or 12 contracts for 1 month each valued at $1,000 each, or a series of contracts costing $1,000 each for 10 months);*

- *Any contract that runs for more than 12 months, the apportioned value of which is $10,000 or more for a 12-month period (e.g., a contract for 18 months valued at $18,000 (the 12-month value is $12,000) or a contract for 24 months valued at $20,000, the 12-month value of which is $10,000); or,*
- *Any contract in which the cost or value of the services or service component is not specified, but the provider-projected services' value is $10,000 or more. (If a contract does not contain the cost or value of the services and does not include the access clause, and it is subsequently determined by an intermediary (or other representative of the HHS Secretary) that the contract is subject to the statute, the provider risks not being reimbursed for the cost of the services under Medicare unless a good faith showing is made that would permit modification of the contract.)*

These contracts between providers and subcontractors may be written or oral. With respect to a written contract, the access clause must be made a part of the contract. Regarding an oral contract, a provider is required to have a written agreement (with a subcontractor) in the form of a letter of understanding that allows access to the pertinent books.

Providers are advised in PRM-1, §2440.4 that the following sample access clause language (which complies with the regulation) may be used:

> *"Until the expiration of four years after the furnishing of the services provided under this contract, (**Name of Subcontractor**) will make available to the Secretary, U.S. Department of Health and Human Services, and the U.S. Comptroller General, and their representatives, this contract and all books, documents, and records necessary to certify the nature and extent of the costs of those services. If (**Name of Subcontractor**) carries out the duties of the contract through a subcontract worth $10,000 or more over a 12-month period with a related organization, the subcontract will also contain an access clause to permit access by the Secretary, Comptroller General, and their representatives to the related organization's books and records."*

This language may not be suitable to all contracts. Therefore, contracting parties may use other clause language provided it contains the elements required in the regulation with respect to the nature of their contractual arrangement. Also, in those cases where the access provision is contained in a document other than the contract to which it applies, the sample clause will have to be modified accordingly.

150.5 – Access Clause Not in Contract
(Rev. 27, 12-19-03)

There may be situations where a provider, after applying the criteria of the regulation to a contract, erroneously decides that the contract does not require an access clause. In such unusual situations, if the provider demonstrates satisfactorily that the decision not to include the clause was made in good faith with a reasonable basis(es), and the

provider and subcontractor amends its contract to include an access clause within an acceptable (to the contractor) period of time after being advised that such amendment is required, the contractor shall treat the contract as meeting the requirements of the regulation. An example of a provider response demonstrating good faith with a reasonable basis is a situation where the provider honestly concluded that the cost or value of the service component of a goods and services contract was less than $10,000. With respect to contracts where services or services and goods are still being provided, any such amendment must make clear that the access clause applies to books, documents, and records for the full term of the contract and not just for the period following the date of amendment. If a provider demonstrates satisfactorily that the decision not to include the clause was made in good faith with a reasonable basis, but cannot amend the contract because the subcontractor is no longer in business, the contractor shall make a determination as to the reasonableness of the costs of the subcontractor's services using available information. The contractor shall take appropriate disallowance and/or recoupment action with respect to the cost of the services of the subcontractor if either the provider or subcontractor refuses to amend the contract, or the provider does not demonstrate satisfactorily that the decision not to include the clause was made in good faith with a reasonable basis.

There may also be situations in which an individual subcontractor refuses to enter into a contract containing the required access clause, or will not agree to the addition of the access clause to an existing contract, which becomes necessary because of a contract modification. Providers are instructed in PRM-1, §2441 to contact the CMS Regional Administrator in their area if they have difficulty in finding another organization that will agree to the clause and offer the needed services at a cost at least as competitive as that of the original organization. (A provider that does not notify the Regional Administrator but instead, on its own initiative, contracts with a more expensive subcontractor or omits the access clause, risks not being reimbursed for the full cost of the services furnished under the contract.) If the Regional Administrator's efforts to persuade a subcontractor to include the required clause are unsuccessful, and no other subcontractor is available that will furnish the services at a competitive price and agree to the access provision, a provider may find it necessary to contract with another organization willing to accept the access clause, even though the cost of the services may be greater. In this situation, providers are requested to contact their contractor before entering into a contract to assure that the greater cost incurred will be considered during the cost report settlement process; this is not intended to be a pre-approval requirement.

150.6 – Reasons for Seeking Access
(Rev. 27, 12-19-03)

If a written accusation (from an HHS or non-HHS party) with suitable evidence against a provider or subcontractor of kickbacks, bribes, rebates, or other illegal activities is received, the intermediary shall prepare a report of the situation and forward it to the regional Office of the Inspector General, HHS. However, if there is reason to believe that the costs claimed by a provider for services of a subcontractor are excessive or

inappropriate, or evidence of possible nondisclosure of the existence of a related organization is discovered, or it is determined that there is insufficient information to judge the appropriateness of the cost(s) claimed by a provider for services of a subcontractor, it may be necessary to examine the books of the subcontractor. Before requesting the subcontractor's books, the intermediary shall determine if there is a more efficient, practical, or economical method of obtaining the necessary information. If there is such a method or other source (e.g., the provider is able to furnish substantiation for the cost of the services), the intermediary shall obtain the needed information by that means before seeking to gain access to the subcontractor's books. If there is no alternate method or source, the intermediary shall seek access, but shall limit the access request to those books germane to the item(s) in question. It shall not make any unnecessarily burdensome or overly intrusive demands on a subcontractor or go on "fishing expeditions."

150.7 – Access Request Procedures (Rev. 27, 12-19-03)

Requests for access must be in writing and contain all of the following elements:

- *Reasonable identification of the books to which access is being requested;*
- *Identification of the subject contract or subcontract;*
- *Reason(s) why the appropriateness of the costs or value of the services of the subcontractor in question cannot be adequately or efficiently determined without access to the subcontractor's books;*
- *Authority in the statute and regulations for the access requested (see §150.1 of this chapter);*
- *If possible, identification of the individual(s) who will visit the subcontractor to obtain access to the books.*
- *Time and date of the scheduled visit; and*
- *Name of the duly authorized intermediary staff member to contact if there are any questions.*

150.8 – Subcontractor Response Requirements (Rev. 27, 12-19-03)

- *A subcontractor has 30 days from the date of a written request for access to books to make them available in accordance with the request.*
- *If a subcontractor believes a request is inadequate because it does not fully meet one or more of the required elements listed in §150.7, it must advise the intermediary of the additional information needed within 20 days from the date of the request. Within 20 days from the date of the intermediary's response*

(providing the additional information), the subcontractor must make the books available.

- *A subcontractor must request (in writing) an extension of time within which to comply with an access request if it believes, for good cause, that the requested material cannot be made available within the 30 day period (e.g., the requested material is located at a home office or in storage and there will be a delay due to retrieval time). If such a request is made, the contractor shall either grant an extension for good cause shown or, if no date can be mutually agreed upon for making the books available, initiate a delay or denial of reimbursement for the cost of the services.*

- *A subcontractor must make requested material available for inspection and audit during its regular business hours.*

  NOTE: *Since subcontractor books subject to access will contain both information germane to the cost item(s) in question as well as other business records (which could be sensitive in nature), CMS recommends that these books, or portions thereof, not be photocopied or otherwise reproduced. Instead, the contractor shall extract the germane information needed and record it in written working papers. If absolutely necessary, the intermediary shall photocopy/reproduce only the germane information.)*

- *If a subcontractor is asked to reproduce books, the contractor shall reimburse the subcontractor for the reasonable costs of reproduction from Medicare funds. However, if a subcontractor reproduces books as a means of making them available, the contractor shall not reimburse the subcontractor for this reproduction.*

- *A subcontractor must, at the request of a contractor, make the originals of any requested books available for inspection.*

150.9 – Refusal of Subcontractor to Furnish Access
(Rev. 27, 12-19-03)

If it is determined that a subcontractor's books are necessary for a reimbursement determination and, despite all efforts, a subcontractor refuses to make them available, the intermediary shall immediately notify the CMS Regional Administrator. If a subcontractor continues to refuse access, legal action may be initiated by CMS against that subcontractor. Also, the Regional Administrator will advise the subject provider that its subcontractor has refused access so that the provider may take whatever action it considers necessary for its financial protection (e.g., withholding of any balances due the subcontractor under the contract).

150.10 – Freedom of Information Act (FOIA) Requests
(Rev. 27, 12-19-03)

If a request is received for release under the FOIA of information obtained from a subcontractor through an access to books action, the intermediary shall immediately refer the FOIA request to:

Centers for Medicare & Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244

NOTE: *The FOIA allows CMS to exempt from mandatory disclosure to requestors certain classes of records, such as trade secrets, confidential commercial or financial information, and personnel and medical files (see 5 United States Code 552(b).)*

160 – Audit Subcontracts

(Rev. 27, 12-19-03)

In accordance with the "Subcontracting and Prior Approval" article of the Contract between the Secretary of Health and Human Services and the contractor, any subcontracting involving a function or duty requires prior written approval. Accordingly, the subcontract for provider audit requires such approval and should be submitted to the appropriate RO.

160.1 – Routing of Audit Subcontract
(Rev. 27, 12-19-03)

The contractor should submit proposed audit subcontracts directly to the RO servicing its area. If its contract responsibilities extend beyond regional boundaries, it should submit the proposed subcontracts to the RO servicing the area in which its home office is located. (See Exhibits X and XI in §170 of this chapter for samples of a model Audit Subcontract Form and Addendum Subcontract, respectively).

160.2 – Required Documentation
(Rev. 27, 12-19-03)

The intermediary should submit the model audit subcontract forms along with the following.

- *Its justification for selecting the proposed audit firm.*

- *Copies of proposals from one or more additional audit firms.*
- *A certification by the contractor to read as follows: our approved budget contains or will contain sufficient funds for the amount requested for this subcontract.*
- *A statement of its estimated percentage of time and costs, if any, to be shared by third parties.*

160.3 – Competition
(Rev. 27, 12-19-03)

The provisions of the prime contract require the use of competitive proposals to the maximum practical extent in the award of subcontracts. The contractor shall obtain proposals from small and minority audit firms and consider their proposals in light of the factors listed below, to the extent that it finds it to be consistent with the efficient performance of the audit function.

The lowest price or lowest cost is the primary deciding factor in source selection, and the intermediary must justify a selection other than the low bidder. However, award of an audit subcontract may properly be influenced by the proposal that promises the greatest value in terms of:

- *Anticipated performance – compliance with Medicare regulations and procedures.*
- *Ultimate productivity – compliance with terms of the contract.*
- *Consideration of the existing and potential workload of the prospective audit firm.*
- *Qualified staff capable of performing Medicare audit.*
- *Prior performance in Medicare audits.*
- *Reputation of the audit firm.*
- *Location of offices.*

170 – EXHIBITS
(Rev. 27, 12-19-03)

Exhibit 1 – Summary of UDR Issues

UNIFORM DESK REVIEW
Summary of Issues

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

Provider Name:		*Settlement without Further Review:*	
Provider Number:		*Desk Review Exception Resolution:*	
Period From:		*Field Audit:*	
To:			

No.	*Reference (See Instrs.)*	*Description*	*Units / $*	*No Further Action*	*Audit Deferred*	*Scoped for Audit*	*Adjusted for Settlement*	*Comments*	*UDR Resolution or Audit W/P Ref.*
1	*2*	*3*	*4*	*5*	*6*	*7*	*8*	*9*	*10*

Exhibit II – Audit Confirmation Letter
(Rev. 27, 12-19-03)

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. In this meeting we will go over outstanding information requests and all of the audit adjustments available at that time (other adjustments may result either from a supervisory review of the work or additional information provided for outstanding items). You will have 4 weeks to provide any outstanding information or information to refute any previously proposed audit adjustment. The final adjustments will be provided to you within 3-4 weeks (or longer if there are extenuating circumstances) after we receive all outstanding information. ***We do not need to consider any additional documentation that you furnish after the***

expiration of the 4-week period related to the outstanding documentation discussed at the pre-exit conference in the Notice of Amount of Program Reimbursement (NPR). If a reopening is later granted or a timely is appeal filed, we may consider this late documentation at that time.

If you wish to have or waive a formal exit conference you must notify the audit and reimbursement manager of this decision in writing shortly after the pre-exit conference. Once the exit conference is held the notice of program reimbursement will be issued within 60 days from the exit conference. 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 III – Entrance Conference Agenda
(Rev. 27, 12-19-03)

Contractor Name:

Provider Name:

____

Provider No.: ____________________ *FYE* ____________________

Auditor: ________________________ *Date:* ___________________

Time: ____________________ *Location* ______________________

Provider Representative:

____

____

____

____

____

Contractor Representative:

____

____

____

____

____

Other:

____

____

____

____

1. Staff Introductions.

2. Provider designation of "Contact" or "Liaison" person for auditors to work with on daily basis.

____

3. Establish a schedule for ongoing communication during the audit to update provider on audit progress, possible audit adjustments, documentation still required, and to share other information.

____

____

- *Establish administrative procedures for such things as:*

  *Use of copy machine*____________________________
  Telephone calls ________________________________
  Use of fax machine _____________________________
  Work hours ____________________________________
  Parking _______________________________________
  Working space _________________________________
  Other ____

- *Establish procedures for obtaining documents and records and their return when the auditors have completed their review.*

  ____

  ____

6. Review last year's audit adjustments as they relate to or affect the current year's cost report/audit.

____

____

7. Discussion of proposed adjustments, if any, to current year's cost report identified during the desk review performed by the contractor.

____

8. Discussion of areas to be audited, steps to be performed and documentation needed as requested in the audit confirmation letter.

9. Discuss the availability of third parties (CPAs, consultants, and other outside parties) and their records related to the cost report, for the auditors.

10. Arranging for tour of provider facility.

11. Establish a tentative date and time for the pre-exit and exit conferences and discuss the proposed agendas for these conferences.

12. Discuss changes in organization ownership, new sub-units, ambulatory care ambulatory care, CORF, SNF, HHA, and Swing Bed.

13. Discuss and update the Internal control Questionnaire, if appropriate.

14. Other questions asked during the entrance conference.

____

____

15. Agenda items from provider (if any).

____

____

Exhibit IV – Internal Control Questionnaire
(Rev. 27, 12-19-03)

This questionnaire is effective for audit fieldwork started after November 30, 1990 and reflects those elements of internal control structure that are more relevant to the outcome of a Medicare audit.

Answer all questions on the questionnaire "Yes," "No," or "Not Applicable," as appropriate and indicate whether the answer was obtained by inquiry, investigation, or both. Provide both name and title of the person supplying the information. Answers requiring support must include proper documentation or explanation, or be cross-referenced to the appropriate working paper in the current audit file. If a brief explanation is sufficient to adequately support the answer, it is not necessary to write an overly detailed description of the procedures.

The questionnaire is not all-inclusive and may be supplemented according to the needs of the provider being audited. If some internal control procedures other than those stated or implied by the questionnaire exist and affect the Medicare audit, include a description or explanation on a supporting working paper.

INTERNAL CONTROL QUESTIONNAIRE

Provider Name ____

Provider Number ____

Reporting Period: From _________________ *To* ________________

a. Question

b. Source (a = Inquiry, b =Observation, c = Tests)

c. Initials of person supplying information. (Initials must be explained and the appropriate title supplied in a supporting working paper)

d. Response (Yes, No, N/A)

e. W/P Reference

Question	***Source***	***Initials***	***Response***	***WP Ref***
I. Control Environment				

Question		Source	Initials	Response	WP Ref
1.	*Was an independent audit of the provider's financial statements for this cost reporting period performed?*				
2.	*If so, what was the audit opinion of the independent auditors?* *Unqualified opinion* *If opinion is qualified, describe the reason why.*				
3.	*Has the provider made a written representation on whether it received a SAS 60 report on reportable conditions of internal control (whether given on a written or oral basis to the provider by the financial auditors)?*				
4.	*Describe any reportable conditions in the SAS 60 report that are applicable to the Medicare audit.*				
5.	*Does the provider have a current organization chart defining lines of responsibility?* *If so, obtain a copy.*				
6.	*Does the provider have an established chart of accounts?* *If so, obtain a copy.*				
7.	*Are the Board of Directors' meeting minutes available for review?* *If so, obtain a copy.*				
8.	*Does the provider have a policy on bonding its employees in positions of financial*				

Question		Source	Initials	Response	WP Ref
	trust?				
9.	*Does the provider have a policy that requires employees in positions of financial trust to take mandatory vacations?*				
10.	*Does the provider have a policy regarding treatment of employees who violate control policies?*				
11.	*List the names of employees exercising the following functions:*				
	President				
	Administrator				
	CFO				
	Controller				
	Medicare Reimbursement Manager				
	Internal Auditor				
	Director of Nursing				
	A. Are any of the above related to each other or others working in the organization?				
	B. If the answer to A. is "yes," list the positions, incumbents, etc., who are related and state the relationships:				

Question		*Source*	*Initials*	*Response*	*WP Ref*
12.	*Does the provider have an internal audit function?*				
	A. If so, does the internal audit function report to an executive other than the chief accounting officer?				
	B. If other than the CEO, specify to whom the internal auditor reports:				

II. Accounting System

1.	*Does the provider have adequate written statements and explanations of its accounting policies and procedures? Do the policies require that:*				
	A. Accounting transactions are recorded in accordance with generally accepted accounting principles (GAAP)?				
	B. Journal entries are approved by a designated individual at an appropriate level? Specify the individual and title:				
	C. Journal entries require an adequate explanation and supporting documentation?				
	D. Monthly reconciliations and timely closings are made to the accounting records.				
2.	*Does the provider maintain a policy manual covering:*				
	A. Approval for financial transactions?				
	B. Guidelines for controlling expenditure functions, such as purchasing and travel authorization?				

Question	Source	Initials	Response	WP Ref
C. Maintenance of accounting records?				
3. Are the provider's accounting and policies and procedures adequately communicated to employees?				
4. Does the provider use a computer system in its accounting operations?				
5. Does the provider have policies and procedures that govern the use and operation of the computer system?				
6. Have accounting principles been consistent with those maintained in the preceding year?				
7. Are periodic interim financial statements prepared and submitted to management?				
8. Does the provider's accounting system have suitable account classifications?				
9. Does the general ledger include accounts of related organizations? If so, identify the accounts and the related organizations.				

III. Control Procedures

Question	Source	Initials	Response	WP Ref
1. Statistics – Worksheet S-3 (or equivalent worksheet):				
A. Does the provider have policies and procedures for accumulating the following census statistics? If so, obtain a copy.				

Question	***Source***	***Initials***	***Response***	***WP Ref***
1. Patient days (including observation bed days).				
2. Patient visits				
3. Number of beds by unit.				
B. Does the provider have written policies and procedures for counting its interns and residents for both indirect medical education and graduate medical education? If so, obtain a copy.				
1. Expenses – Worksheet A:				
A. What is the source document for the expenses filed on Worksheet A of the cost report?				
B. Are credits and refunds from vendors properly controlled and recorded to ensure that expenses are not overstated?				
C. Payroll expenses:				
1. Are employees required to punch a time clock or equivalent time logging system?				
2. Is the payroll periodically checked against personnel records for:				
Continuing employment?				
Rate of pay?				
3. Is the payroll checked for departmental allocation and time worked?				

Question	*Source*	*Initials*	*Response*	*WP Ref*

4. What documentation does the provider have to support its physicians' salary allocations to the provider component, the professional component, and the teaching component?

5. If an employee works in two departments, how is the time split supported?

3. Cost allocation statistics – Worksheet B-1:

A. List each cost allocation statistic.

1. Obtain a written description from the provider describing how each type of statistic is accumulated and maintained.

2. If the method for accumulating any statistic is different from that of prior cost reporting periods, obtain a description and explanation of the change. This includes changing from time records to time studies.

B. What are the provider's procedures for requisitioning drugs and medical supplies from inventory and allocating them to departments?

4. Patient Care Charges – Worksheet C:

A. What is the source document for reporting charges on Worksheet C of the cost report?

B. Obtain a copy of the written procedures describing how routine,

	Question	Source	Initials	Response	WP Ref
	intensive care, ancillary, outpatient, and other patient care charges are recorded and accumulated by the provider.				
	1. Does the provider have procedures to ensure that the same charge is recorded for all classes of payers for the same service?				
	2. Does the provider have procedures in place to ensure that all charges are properly recorded:				
	In accordance with the provider's charge schedule?				
	In the correct department?				
	As inpatient or outpatient?				
	3. Does the provider have procedures in place to ensure that adjustments to billed charges are properly credited to the correct department?				
5.	*Billing and Collection:*				
	A. Medicare as Secondary Payer – Does the provider have procedures in place to:				
	1. Obtain information on primary and secondary payers from patients on admission or at time of outpatient service?				
	2. Revise the billing where the primary payer is identified subsequent to the original billing?				
	3. Review credit balances and				

Question	Source	Initials	Response	WP Ref
to remit them when they arise from subsequent identification of the correct primary and secondary payers?				
B. What is the provider's collection policy for unpaid patient bills?				
1. Does the provider have the same collection policy and procedures for both Medicare and non-Medicare patients?				
2. Does the provider use a collection agency?				
C. What is the provider's policy in writing off Medicare bad debts as uncollectible? Obtain a copy.				
1. Does the provider have policies in place to determine indigence?				
2. Are the amounts written off as Medicare bad debts related only to covered deductible and coinsurance amounts?				
D. Does the provider have procedures in place to identify recoveries of bad debts previously written off and charged to the Medicare program?				
6. Capital-related costs:				
A. What are the provider's formal capitalization and depreciation policies? Obtain a copy.				

Question	*Source*	*Initials*	*Response*	*WP Ref*
B. Does the hospital directly assign capital-related costs to departments? If so, what are the provider's policies and procedures on directly assigned capital costs?				
C. How does the provider record additions, transfers, and retirements?				
D. What follow-up procedures exist which ensure the proper handling of the gain or loss from the sales of assets?				
E. How are records maintained for equipment and facilities used by the hospital, but owned by others?				
F. At what level does the provider require normal authorization for new or renewed loans?				
G. How does the provider ensure that all investment income, profits (and losses to the extent applicable) arising from funds diverted from patient care are properly offset against interest expense?				

EXHIBIT V – Pre-Exit Conference Format
(Rev. 27, 12-19-03)

Contractor Name:

____

Provider Name:

____

*Provider No:*___________________________ *FYE:*______________________

*Auditor:*_______________________________ *Date:*______________________

*Time:*_________________________________ *Location:*____________________

Provider Representative:

____

____

____

____

Contractor Representative:

____

____

____

____

Other:

____

____

____

____

1. Discussion of proposed adjustments

____

____

2. Discussion of documentation that is still needed by the auditor to complete his/her review.

____

____

3. Define responsibilities for all open items.

____

____

4. Establish timeframes for:
a.Providing documentation to auditors

____

____

b. Provider responding to proposed audit adjustments.

____

____

c. Response by contractor to provider once documentation is received.

____

____

d. Receipt of final adjustments.

____

____

e. Contractor to provide adjustment work papers as requested by provider.

____

____

5. Assure all provider records are returned.

____

____

Exhibit VI – Audit Adjustment Report
(Rev. 27, 12-19-03)

Instructions for Completion of the Audit Adjustment Report

A – Heading

Complete as indicated.

B– Adjustment Numbers

List adjustments in the order of completion of the cost report; i.e. cost report worksheet order and number them consecutively as they are recorded on the adjustment report.

C – Report Reference

Identify the CMS form, page number or worksheet, line number, and column number to which the adjustment applies. For example, reference to Form CMS-2552-96, Worksheet C, Part I, line 37, column 6, Operating Room (the cost center affected by the application of the adjustment), would indicate an adjustment to revise/remove total inpatient charges reported for the Operating Room.

D – Explanation of Adjustment

Provide a narrative description of the audit adjustment. The description should be adequate enough to identify the item being adjusted and the reason (e.g., decreasing the GME FTE count of interns and residents, removing nonallowable cost, reclassifying cost or other data). The narrative description of the audit adjustment should also include appropriate reference to law, regulations, or program policy and procedures, and the contractor's working paper where the adjustment was first proposed.

E – W/S A Line

For adjustments pertaining to Wkst. A-6 and Wkst. A-8, indicate in this column the Wkst. A lines that are affected by the adjustment. For example, if vending machines expenses were included on Line 8 of Wkst. A, any Wkst. A-8 adjustments increasing or reducing the those expenses will affect Wkst. A, Line 8. Thus in the W/S A Line column insert "8".

F – CODE

Indicate in this column the letters that are used to identify the Wkst. A-6 reclassification adjustments. For example, the first Wkst. A-6 reclassification adjustment should be annotated with the letter that follows the last letter used for reclassifications on the "submitted" Wkst. A-6. All the subsequent reclassification adjustments should follow the letters in the alphabet. If all the letters of the alphabet are used up and there are other

reclassification adjustments to be made, double the letters starting with "A". For example, use "AA" as the adjustment that follows "Z".

G – Basis

Insert in this column the type of Wkst. A-8 adjustment. For "cost' adjustments use "A" and for "income offsets" use "B".

H – As Reported or As Adjusted

- *As Reported – show the amount included in the unaudited cost report for the cost center that will be affected by the adjustment. For example, where the proposed adjustment will change the employee benefits statistical allocation of the Administrative & General (A&G) cost center as reported by the provider, the amount shown will be the statistic as reported for this cost center on Form CMS-2552-96, Worksheet B-1, line 6, column 5.*

- *As Adjusted – where the A&G cost center has previously been adjusted by the audit capability, the contractor shall insert in this column the amount shown "As Adjusted" for the previous adjustment. Reference should be made to this previous adjustment, e.g., (see adjustment no. 1).*

I – Increase (Decrease)

Insert the amount of the adjustment. The adjustment amount should be indicated by brackets if it represents a (decrease) of the amount in the "As Reported or As Adjusted" column.

J – As Adjusted

This column is the result of adding or subtracting the adjustment amount from the previously reported amount.

AUDIT ADJUSTMENT REPORT *(Sample Format)*

These adjustments will be incorporated in our revised ***Statement of Reimbursable Cost*** *for the period ended ______________.*

Provider # _____________________________
Provider Name _________________________
Fiscal Year ___________________________

Adj.		Pg or			Explanation of	W/S A	A-6		As Reported	Increase or	
No.	Form	Sch	Line	Col	Adjustment	Line #	Ltr.	Basis	or As Adjusted	(Decrease)	As Adjusted
1	2552-96	S-3	1	4	Hospital Adults & Peds				34,400	125	34,525

		Part I	6		ICU				812	(89)	723
			7		CCU				791	24	815
					To revise Title XVIII inpatient days to						
					agree to the PS&R paid through						
					12/31/02. 42 CFR 413.64 &						
					CMS 15-I, §2404. W/P 15-2						
2	2552-96	A-6	1	4	Nonallowable Marketing – Salaries	99.01	Z		$ –	$ 252,000	$ 252,000
				5	Nonallowable Marketing – Other	99.01			–	153,000	153,000
				8	Nonallowable Marketing – Salaries	6			–	(252,000)	(252,000)
				9	Nonallowable Marketing – Other	6			–	(153,000)	(153,000)
					To reclassify Marketing Expense to						
					a nonreimbursable cost center, so						
					that it receives its appropriate share						
					of overhead. 42 CFR 413..9 &						
					CMS 15-I, §2136. W/P 4-3						
3	2552-96	A-8	22	2	Vending Machines	8		B	$ –	$ (11,690)	$ (11,690)
					To offset income earned from						
					vending machines. 42 CFR 413.9 &						
					CMS 15-I, §2102..3. W/P 4-4B						
4	2552-96	B-1	6	5	Administrative & General				$ 5,659,255	$(252,000)	$5,407,255
			99.01		Nonallowable Marketing				–	252,000	252,000
					To reflect adjustments made to						
					salaries for the Employee Benefits						
					statistic as the stat is based on						
					Gross salaries. 42 CFR 413.24 &						
					CMS 15-I, §2306. W/P 11-6						
5	2552-96	C	37	6	Operating Room				$ 2,875,965	$ 342,105	$3,218,070
		Part I									
					To revise Inpatient Operating Room						
					charges to agree to the provider's						
					trial balance. 42 CFR 413.24 &						
					CMS 15-I, §2304. W/P 15-2						

6	2552-96	D-4	37		Operating Room				$ 716,479	$ 25,452	$ 741,931
			41		Radiology – Diagnostic				332,735	3,125	335,860
			44		Laboratory				660,777	105,410	766,187
			50		Physical Therapy				138,455	36,500	174,955
					To adjust the Title XVIII Inpatient						
					Charges to agree to the PS&R						
					paid through 12/31/02.						
					42 CFR 413.53 & CMS 15-I, §2204.						
					W/P 15-2						
7	2552-96	E	21	1	Reimbursable Bad Debts				$ 33,450	$ (3,200)	$ 30,250
		Part A									
					To adjust Part A Bad Debts to						
					remove those bad debts written off						
					prior to 120 days. 42 CFR 413.80						
					CMS 15-I:310.2. W/P 14-1B						
8	2552-96	E-1	1	2	Interim Payments Paid				$ 7,121,387	$ 125,600	$7,246,987
			2		Interim Payments Payable				154,955	(154,955)	–
					To adjust Interim Payments to						
					agree to the PS&R paid through						
					12/31/02. 42 CFR 413.64 &						
					CMS 15-I,§2404. W/P 15-5						
9	2552-96	E-3	3.07	1	Weighted FTE Count for Primary Care Residents				150.55	-2.34	148.21
		Part IV	3.08		Weighted FTE Count for All Other Residents				95.40	-1.02	94.38
			3.11		Weighted Dental & Podiatric FTE Count				11.00	-0.55	10.45
					To adjust the GME FTE count to agree to the						
					provider's rotation schedules. 42 CFR 413.86						
					W/P 13-8G						

Exhibit VII – Form of Report on Audit of Medicare Cost Report (Rev. 27, 12-19-03)

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 government auditing standards (GAS). 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

Exhibit VIII – Form of Report for Medicare Cost Report That Has not Been Audited
(Rev. 27, 12-19-03)

CONTRACTOR LETTERHEAD

PROVIDER NAME ____

PROVIDER NUMBERS ____

*REPORTING PERIOD FROM*___________________*TO*_________________

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

Preparation of the cost report and compliance with Medicare laws, regulations, and instructions are the responsibility of the provider(s) management.

We have performed a review of the cost report. The attached Medicare cost report has been adjusted, where required, for items of noncompliance discovered during our review, which are listed in the attached adjustment report.

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

(Signature)

Name and Title

NPR Date

Exhibit IX – Personal Impairments Statement (Rev. 27, 12-19-03)

I certify that I am free of personal or financial impairments on this assignment/the assignments that I will be involved during the fiscal year. These personal impairments may include, but are not limited to the following:*

- *Official, professional, personal, or financial relationships that might cause me to limit the extent of the inquiry, to limit disclosure, or to weaken or slant audit findings in any way.*
- *Preconceived ideas toward individuals, groups, organizations, or objectives of a particular program that could bias the audit.*
- *Previous responsibility for decision-making or managing the entity that would affect current operations of the entity or program being audited.*
- *Biases that result from employment in, or loyalty to, a particular group, organization, or level of government.*
- *Subsequent performance of an audit by myself if, for example, I have previously approved invoices, payrolls, claims and other proposed payments of the entity or program being audited.*
- *Concurrent or subsequent performance of an audit by myself, if I had previously maintained the official accounting records.*
- *Financial interest, direct or substantial indirect, in the audited entity or program.*
- *Job offer received during the engagement.*

Signature: ______________________

Date: ______________________

Approval: ______________________

*Date:*______________________

** (Underline the applicable phrase depending whether the impairment statement applies to a single assignment or represents an annual impairment statement.)*

Exhibit X – Model Audit Subcontract Form
(Rev. 27, 12-19-03)

THIS CONTRACT between ____________________________, hereinafter referred to as the "Intermediary" and __________________________, hereinafter referred to as the "Audit Firm" shall begin on _________________, and shall end on _________________.

ARTICLE I

Auditing Services

A. General

1. To the extent directed by the Intermediary, the Audit Firm shall examine the records of those providers of services designated by the Intermediary, and shall report any matters noted in the course of the examination which reflect upon the allowability of costs reported by the providers. Such costs are defined in §1861 (v) of the Social Security Act, as amended, hereinafter referred to as the "Act," and in the Principles of Reimbursement for Provider Costs (42 CFR 405.465 - 405.482 and 42 CFR 413.1 -413.178), hereinafter called "Principles." Based on Public Law 94-505, audits performed under the Act must adhere to the applicable Standards for Audits of Governmental Organizations, Programs, Activities, and Functions issued by the Comptroller General of the United States. These standards are covered in §4112 of CMS Publication 13-4.

2. The audit for each provider shall commence and be completed within the timeframes specified in Appendix B. A request for an extension of time must be in writing and will be allowed only for "good cause" as determined by the Intermediary. Any delays arising out of causes, which are beyond the control and without the fault or negligence of the audit firm, shall constitute "good cause" for an extension of time to complete an audit.

3. The Audit Firm may, with Intermediary approval, undertake preliminary work prior to the official commencement of the audit.

B. The Audit Firm shall audit designated providers as indicated in Appendix B in accordance with Generally Accepted Auditing Standards applicable in the circumstances. The Intermediary will provide written instructions as to the extent of the audit, as well as the maximum number of hours allocated for the audit. For the purpose of this Article, if the Audit Firm is an independent Certified Public Accounting (CPA) Firm it must meet the criteria for independence in the Code of Professional Ethics published by the American Institute of Certified Public Accountants. Further, the Audit Firm will promptly disclose to the Intermediary, in writing, any auditing or Management Advisory Services (MAS) rendered to a provider which the Intermediary directs it to audit.

C. Where the Audit Firm has conducted an examination, the Audit Firm's report must include the following:

1. *Audit working papers detailing work performed which supports the audit findings.*

2. *Audit adjustments prepared in the format required by the Intermediary, as prescribed by the Centers for Medicare & Medicaid Services (CMS), to be discussed with provider officials. The Audit Firm will be present at these meetings.*

D. The Audit Firm agrees to advise the Intermediary, as soon as possible, of any matters coming to its attention during the course of the audit that, in the Audit Firm's opinion, indicate the need for additional auditing. Such advice shall be in sufficient detail so as to enable the intermediary to establish the need for additional work. As time is of the essence, the intermediary will respond orally before the end of two business days following receipt of such advice and confirm in writing.

E. Final acceptance for all work called for herein will be made by the Intermediary when it determines that all technical requirements under the contract have been satisfactorily met. Any corrections or adjustments necessitated by the Audit Firm's failure to comply with the specifications will be made at no additional expense to the United States Government.

F. All audit work to be performed under this Contract shall be performed directly by members or employees of the Audit Firm and no functions shall be subcontracted to any other person or firm, unless approved in advance, in writing, by the Intermediary and CMS. The Audit Firm agrees not to assist any provider of services for which it is performing the Medicare audit under this Contract in the resolution of any dispute between the provider of services and the Intermediary or CMS, arising as a result of any audit performed under this Contract.

ARTICLE II

Compensation for Services Performed Under This Contract

A. The Intermediary shall compensate the Audit Firm for its direct and indirect audit time, travel, and incidental audit expenses. Direct audit time is defined as the time of personnel specifically spent in the conduct of an audit under the terms of this Contract. Indirect time is time spent by personnel in relation to audits under this Contract of two or more providers which cannot be specifically identified with the audit of either provider.

The Audit Firm agrees to furnish the total number of hours of audit work at the rate and total dollar amount not exceeding those specified in Appendix A, and to audit those providers as directed by the Intermediary. The audit firm shall be paid an hourly rate, reasonable incurred travel costs and incidental out-of-pocket expenses, as compensation for the work performed under this contract, subject to the limitations of this Article. The Audit Firm shall not be compensated when the total amounts of its charges exceed the dollar amount specified in Appendix A. The Audit Firm shall not be compensated for any audit work performed at a provider of services after it has been directed by the Intermediary not to initiate that audit or to discontinue audit work in progress. Audit Firms shall not charge training of their staff to this Contract.

B. The Intermediary shall reimburse the Audit Firm for all reasonable incurred travel costs in accordance with the guidelines for travel in the Federal Acquisition Regulations (FAR) §31.205-46, as outlined in subparagraphs 1 and 2 below. Travel costs are those

expenses for transportation, lodging, subsistence, and related items incurred by any member or employee of the Audit Firm in the performance of functions under this Contract. Such costs may be charged on an actual basis, a per diem or mileage basis in lieu of actual costs incurred, or a combination of the two. The method used shall apply to an entire trip and not to selected days of the trip.

1. *Costs incurred for lodging, meals and incidental expenses shall be considered to be reasonable and allowable only to the extent that they do not exceed on a daily basis the maximum per diem rates in effect at the time of travel as set forth in the Federal Travel Regulations.*
2. *Airfare costs in excess of the lowest customary standard coach, or equivalent airfare offered during normal business hours are unallowable except when such accommodations require circuitous routing, require travel during unreasonable hours, excessively prolong travel, result in increased cost that would offset transportation savings, are not reasonably adequate for the physical or medical needs of the traveler, or are not reasonably available to meet mission requirements.*

C. The Audit Firm's hourly rates for services to be performed by its members and employees under this Contract shall not exceed those specified in Appendix A.

D. The Audit Firm shall submit to the Intermediary, at least monthly, billings for total services rendered, showing Hourly Rates times the Number of Hours, with separate entries for total travel and incidental out-of-pocket expenses. In addition, the Audit Firm shall attach to each monthly billing a listing of the providers to which the billing applies and the audit fees associated with each provider, including the corresponding hour(s). Included in the listing, as separate items, shall be the cost of indirect time and incidental expenses so that the total shown will agree with the total in the monthly billing. Within 30 calendar days after the completion or termination of an audit, the Audit Firm will submit a summary of the direct time for performing the audit of that provider. Within 30 days after the completion of this Contract, the Audit Firm shall submit a summary of indirect time for each provider of services audited under this Contract. The Intermediary shall make prompt payment to the Audit Firm, upon receipt of monthly billings, to the extent such compensation, travel, and incidental out-of-pocket expenses are supported under this Article; however, the Intermediary must be satisfied with the quality of the audit before final settlement.

E. When the Audit Firm is delinquent in submitting any working papers as required under Article I.A., and C., of this Contract, the Intermediary shall have the right to suspend all payments to the Audit Firm until such time as the Intermediary determines that the Audit Firm is current in processing audits to completion and in submitting working papers. The Audit Firm shall be considered current when it meets the requirements of Article I.A.2 regarding the submission of working papers.

F. The Audit Firm shall maintain adequate accounting records covering the funds received under this Contract. The Audit Firm agrees that the Intermediary until 3 years after final payment for the term of this Contract, shall have access to and the right to examine, upon reasonable notice, the records involving transactions related to this Contract.

G. This contract does not provide for indemnification of the Audit Firm or any of its directors, officers or other employees for its wrongful acts or conduct stemming from the Medicare audit. Thus, in the event of a lawsuit or administrative proceeding the Audit Firm is totally responsible for any adverse judgments or awards rendered against it and/or related costs and legal fees.

ARTICLE III

Amendments Due to Increases in Charges

If, during the term of this Contract, the Audit Firm determines or anticipates that its charges in carrying out the terms of this Contract will exceed the total amount stated in Appendix A, it shall request, in writing, that the Intermediary provide a funding increase and shall furnish adequate data to support such request.

A. If the requested increase, by itself, does not exceed $10,000, or when added to previous Contract increases does not exceed fifteen percent of the total Contract amount, the Intermediary shall determine within seven calendar days the extent to which the increase will be made. The Contract will then be amended to reflect the appropriate amount of increase.

B. If the requested amount of increase exceeds $10,000, or when added to previous increases on this Contract exceeds fifteen percent of the total Contract amount, the Intermediary shall forward the Contract amendment to CMS for approval.

ARTICLE IV

Amendments Due to Increase and/or Decrease in Number of Providers of Service

A. The Intermediary and the Audit Firm may at any time agree to increase or decrease the number of providers to be audited under this Contract, as specified in Appendix B.

B. The Intermediary shall have the right to reduce the number of Audits of providers as specified in Appendices A and B, or to direct that audit work in progress be discontinued, upon the giving of prior written notice to the Audit Firm. The reduction or direction to discontinue work shall become effective on the date specified in the notice.

C. In the event of any increase or decrease in the number of providers to be audited under this contract as specified in Appendices A and B, which does not cause a complete termination of this Contract, the Audit Firm and the Intermediary agree that the total estimated maximum amount stated in Appendix A shall be appropriately adjusted.

D. The Intermediary's obligation under the contract is contingent upon the availability of appropriated funds from which payment for contract purposes can be made.

ARTICLE V

Questions and Interpretations

The Audit Firm shall refer questions of interpretation of the Act or Principles of Medicare Reimbursement to the Intermediary and the written reply of the Intermediary will be considered as conclusive.

ARTICLE VI

Term of the Contract

The term of this Contract shall begin and end on the dates cited on page 1. If the cost report for any provider of services is received by the Audit Firm during the term of this Contract, at a time when completion of the audit by the ending date of the contract is not possible, the Audit Firm will continue to assist in performing the audit under this Contract if sufficient audit hours and money are still available. (See Article II, Paragraph A.)

ARTICLE VII

Termination of Contract

A. The Intermediary and the Audit Firm may terminate this Contract at any time by mutual consent.

B. This Contract shall automatically be terminated when the services described in Article I have been completed for all providers of services for which cost reports have been received by the Audit Firm during the term of this Contract. In the event the Intermediary reduces the number of audits specified in Appendix B to be performed under this contract, the contract shall be terminated upon the completion of all remaining audits.

C. In the event of any termination under this Article or under any other provision of this Contract, the Audit Firm shall, as promptly as possible, but not later than 30 calendar days after the date of such termination, submit a summary including the direct time for provider audit work performed, travel, incidental out-of-pocket expenses, and any indirect time chargeable under this Contract.

ARTICLE VIII

Disputes

Except as otherwise provided in this Contract, any dispute concerning a question of fact arising under this Contract, which is not disposed of by agreement, shall be decided by an official authorized to bind the Intermediary who shall mail or otherwise furnish a copy of the decision to the Audit Firm.

ARTICLE IX

Appendices

Appendix A, Appendix B, and the "Addendum to Subcontracts Under the Health Insurance for the Aged and Disabled Act" attached hereto, are made a part of this Contract.

ARTICLE X

Contract and Amendment Approval

The Intermediary and the Audit Firm acknowledge that this Contract, and any amendments over $10,000 or exceeding fifteen percent of the total contract amount are not to be effective until approval, in writing, by the Secretary.

IN WITNESS WHEREOF, the parties hereby execute this agreement this

_______ day of __________ 19 _______.

____

(Audit Firm)

____

____

(Address of Audit Firm)

By: ____

(Signature) (Title)

(Intermediary)

By: ____

(Signature) (Title)

(Blue Cross/Blue Shield Association)

By: ____

(Signature) (Title)

Approved:

Secretary of Health and Human Services

By :___________________________________

Signature

APPENDIX A

HOURLY RATE OF AUDIT FIRM PERSONNEL

CATEGORY OF COSTS	***HOURLY RATE***	***HOURS***	***AMOUNT***
FLAT RATE			
TRAVEL COSTS			
INCIDENTAL COSTS			
TOTAL			

APPENDIX B

List of Providers of Services to be Audited

Name of Provider & Estimated Audit Completion Date	***City***	***FYE***	***Estimated Hours***	***Estimated Amount***	***Travel Cost***	***Incidental Costs***

(Title)

This_____________ day of _____________20____

Exhibit XI – Addendum to Subcontract
(Rev. 27, 12-19-03)

Addendum to Subcontract Under the
Health Insurance for the Aged and Disabled Act
(42 U.S.C., Chapter 7, Supp., as Amended)

The clauses of this Addendum are a part of and are applicable, as indicated, to the subcontract by and between ____________________________, hereinafter referred to as the "Contractor" and ___________________________, hereinafter referred to as "Subcontractor." The term "Secretary" as used herein, means the Secretary of Health and Human Services or his delegate unless specified otherwise.

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NOTE: *If there are any questions by the Subcontractor as to the applicability of the above clauses to this subcontract or whether the Subcontractor will be performing under this subcontract one of the Medicare "functions" or other responsibilities requiring prior approval of the Secretary as provided in the Medicare agreement between the Contractor and the Secretary, clarification should be requested from the Contractor in writing prior to execution hereof.*

SECTION I

The clauses in §I are applicable to this subcontract (and to lower tier subcontracts hereunder) unless excluded by the virtue of the lead-in language or other provisions contained in the body of the individual clauses.

Clause I

FACILITIES NONDISCRIMINATION CLAUSE

The following provisions are applicable if this subcontract is for the lease of real estate:

"As used in this clause, the term "Facility" means stores, shops, restaurants, cafeterias, restrooms, and any other facility of a public nature in the building in which the space covered by this lease is located."

"The lessor agrees that he will not discriminate by segregation or otherwise against any person or persons because of race, color, religion, sex, or national origin in furnishing or by refusing to furnish, to such person or persons, the use of any facility, including any or all services, privileges, accommodations, and activities provided thereby. Nothing herein shall require the furnishing to the general public of the use of any facility customarily furnished by the lessor solely to tenants, their employees, customers, patients, clients, guests and invitees."

"It is agreed that the lessor's noncompliance with the provisions of this clause shall constitute a material breach of this lease. In the event of such noncompliance, the lessee in acquiring substitute space. Substitute space shall be obtained in as close proximity to the lessor's building as is feasible and moving costs will be limited to the actual expenses thereof as incurred."

"The lessor agrees to include, or to require the inclusion of the foregoing provisions of this clause (with the terms "lessor" and "lessee" appropriately modified) in every agreement or concession pursuant to which any person other than the lessor operates or has the right to operate any facility. Nothing herein contained, however, shall be deemed

to require the lessor to include or require the inclusion of the foregoing provisions of this clause in any existing agreement or concession arrangement or one in which the contracting party other than the lessor has the unilateral right to renew or extend the agreement or arrangement, until the expiration of the existing agreement or arrangement and the unilateral right to renew or extend. The lessor also agrees that it will take any and all lawful actions as expeditiously as possible with respect to any such agreement as the contracting agency may direct to enforce this clause, including but not limited to termination of the agreement or concessions and institution of court action."

Clause II

DISCLOSURE OF INFORMATION

This clause is applicable to this subcontract and to any lower tier subcontract hereunder if it provides for the performance of any of the functions required for the administration of the Medicare agreement between the Contractor and the Secretary, and to any other subcontract where the subcontractor, its agents, officers, or employees might reasonably be expected to have access to information within the purview of §1106 of the Social Security Act, as amended, and regulations prescribed pursuant thereto.

"The Subcontractor agrees to establish and maintain procedures and controls so that no information contained in its records or obtained from the Contractor and/or the Secretary or from others in carrying out the terms of this subcontract shall be used by or disclosed by it, its agents, officers, or employees except as provided in §1106 of the Social Security Act, as amended, and Regulations prescribed thereunder."

Clause III

AUTOMATIC TERMINATION OF SUBCONTRACT CLAUSE

This clause is applicable to this subcontract if its term exceeds the term of the agreement between the Secretary and the Contractor, except where the Secretary agrees to its omission or if this subcontract is solely for the purchase of supplies and equipment.

Notwithstanding the following, if the Contractor wishes to continue the subcontract relative to its own business after the contract between the Secretary and the Contractor has been terminated or nonrenewed, it may do so provided it assures the Secretary in writing that the Secretary's obligations will terminate at the time the Medicare contract terminates or is nonrenewed subject to the termination cost provisions provided for in the contract.

The clause is as follows:

"In the event the Medicare contract between the Secretary and the Contractor is terminated, the subcontract between the Contractor and the Subcontractor will be terminated unless the Secretary and the Contractor agree to the contrary. Such termination shall be accomplished by delivery of written notice to the Subcontractor of the date upon which said termination will become effective."

Clause IV

LIQUIDATED DAMAGES IN SUBCONTRACTS

The following provisions are applicable to this subcontract if it contains liquidated damages provisions which relate solely to Medicare:

The Secretary, after consultation with the Contractor, shall have the right to determine that the specified levels of performance have not been attained by the Subcontractor. In such event, the Secretary may direct the Contractor to notify the Subcontractor of the Secretary's determination that liquidated damages apply and to set-off the liquidated damages against the Subcontractor.

Clause V

PRIVACY ACT

The Privacy Act of 1974, Public Law 93-579, and the Regulations and General Instructions issued by the Secretary pursuant thereto, are applicable to this subcontract, and to all subcontracts hereunder to the extent that the design, development, operation, or maintenance of a system of records as defined in the Privacy Act is involved.

Clause VI

COST AND PRICING DATA

This clause is applicable to this subcontract and to any modification thereof, (1) where the estimated cost to Medicare exceeds or will exceed $500,000, and (2) the estimated cost was not based on adequate price competition, established catalog or market prices of commercial items sold in substantial quantities to the general public, or prices set by law or regulation.

The Subcontractor is required to submit written cost or pricing data and certify that the data submitted was accurate, complete and current at the time of entry into this subcontract or modification in accordance with Subpart 15.804 of the Federal Acquisition Regulation and to maintain full and complete accounting records to support cost or pricing data submitted. The Subcontractor must provide for full access by the Contractor, the Secretary, and the Comptroller General of the United States for the purpose of examining the accuracy of cost or pricing data submitted as aforesaid, and in accordance with Subpart 15.804 of the Federal Acquisition Regulation, agrees to a reduction in price if the cost or pricing data submitted is found to be defective.

SECTION II

In addition to the clauses in §I, the clauses contained in §II are also applicable to this subcontract regardless of amount if the subcontract (a) provides for the performance of any of the functions required for the administration of the Medicare agreement between the Contractor and the Secretary, or (b) involves subcontracting for automated data

process systems or facilities management services which required the Secretary's prior approval.

Clause VII

SUBCONTRACTING OF RESPONSIBILITIES

The Subcontractor agrees that it shall not enter into any lower tier subcontract with any other party to carry out the primary responsibilities of this subcontract without the prior written approval of the Secretary. In the event such approval is given, the Subcontractor further agrees that the substance of these clauses shall be inserted in each such lower tier subcontract.

Clause VIII

INSPECTION

The Secretary shall have the right, at all reasonable times and upon reasonable notice, to inspect or to otherwise evaluate the work performed or being performed under this subcontract, and the premises in which it is being performed. If an inspection or evaluation is made, the Subcontractor shall provide all reasonable facilities and assistance for the safety and convenience of the Secretary's representatives in the performance of their duties. All inspections and evaluations by the Secretary's representatives shall be performed in such a manner as will not unduly delay the work.

Clause IX

RIGHTS IN DATA

A. The Subcontractor agrees that the Secretary shall at such times and in such manner as he may prescribe, have access to any data acquired or utilized by it in the development and processing of claims or in carrying out its other functions under this subcontract, and further, shall have use of such data (other than discrete data such as trade secrets, commercial or financial data obtained solely from private business of the Subcontractor). The Subcontractor shall also, at such times and in such manner as the Secretary may prescribe, furnish to other organizations for use in administering health care or health care financing programs under the Act, data acquired or utilized by it in the development and processing of claims or other data (other than discrete data such as trade secrets, commercial or financial data obtained solely from private business of the Subcontractor) acquired by it in carrying out its functions under this subcontract. This does not apply to the proprietary data of subcontractors which is utilized by the Contractor for program purposes.

B. As used in this clause, the term "Subject Data" means writings, sound recordings, pictorial reproductions, drawings, designs, or other graphic representations, all systems documentation, program logic, operational manuals, forms, diagrams, workflow charts, equipment descriptions, data files, data processing or computer programs, all other operational methods and procedures involved in the performance of functions under the

subcontract and works of any similar nature (whether copyrighted or copyrightable) which are acquired or utilized by the Subcontractor in carrying out its functions under this subcontract, for which more than 50 percent of the cost of development has been paid out of Government funds. The term does not include financial reports, cost analyses, and similar information incidental to contract administration.

C. Government rights. Subject only to provisions of (D) below, the Government may use, duplicate or disclose in any manner, and for any purpose whatsoever, and have or permit others to do so, all Subject Data.

D. License to copyright data. In addition to the Government rights as provided in (C) above with respect to any Subject Data which may be copyrighted, the Subcontractor agrees to and does hereby grant to the Government a royalty-free, nonexclusive, and irrevocable license throughout the world to use, duplicate or dispose of such data in any manner and for any purpose whatsoever, and to have or permit others to do so; provided, however, that such licenses shall be only to the extent that the Subcontractor now has, or prior to completion or final settlement of this subcontract may require, the right to grant such license without becoming liable to pay compensation to others solely because of such grant.

E. Relation to patents. Nothing contained in this clause shall imply a license to the Government under any patent or be construed as affecting the scope of any license or other right otherwise granted to the Government under any patent.

F. Marking and identification. The Subcontractor shall not affix any restrictive markings upon any Subject Data, and if such markings are affixed, the Government shall have the right at any time to modify, remove, obliterate, or ignore any such markings.

G. Deferred ordering and delivery of data. The Government shall have the right to order, at any time during the performance of this subcontract, or within two years from either acceptance of all items to be delivered under this subcontract or termination of this subcontract, whichever is later, any Subject Data, or data generated in performance of the subcontract developed with Government funds, and the Subcontractor shall promptly prepare and deliver such Subject Data or data as may be required. When Subject Data is delivered pursuant to this paragraph G, payment shall be made for converting the Subject Data or data into the prescribed form, reproducing it or preparing it for delivery. The Government's right to use data delivered pursuant to this paragraph G shall be the same as the rights in Subject Data as provided in (C) above. The Subcontractor shall be relieved of the obligation to furnish Subject Data or data upon the expiration of two years from the date it accepts such items.

H. The Subcontractor shall retain such data or Subject Data subject to the time limit imposed by the Examination of Records clause of this Addendum and the right to examine such records by the Comptroller General of the United States and the Secretary including their duly authorized representatives).

Clause X

SUBCONTRACTOR AS COMMON SUBCONTRACTOR

In the event a systems change, as designated by the Secretary, is required as the result of an act of Congress, Regulation, or General Instruction, and it applies to more than one Medicare contractor for which the Subcontractor ("Common Subcontractor") provides similar services, each contractor shall individually arrange for the common Subcontractor to implement such change to its system. If an increase in cost is sought by the Common subcontractor for the modification, the Contractor shall pay a reasonable price, based upon certified cost or pricing data submitted by the Common Subcontractor. As soon as possible thereafter, the Contractor shall submit the supporting data, along with all other pertinent documentation, to the Secretary. On a basis to be determined by the Secretary, a reasonable price shall then be established for the common systems change as implemented by all affected contractors and such price shall be divided among those contractors. The cost of any additional modifications needed to meet the specific requirements of a particular contractor shall be borne only by that contractor. Should the Secretary determine that the increase in price for the common change or other modification is not adequately supported, the Common Subcontractor agrees to refund such amount to the Contractor. In the event the Common Subcontractor refuses to refund the above amount, the Secretary may request that the contractor take action to recover from the Common Subcontractor that portion of the price which the Secretary finds to be unsupported. The Secretary shall reimburse the Contractor for all reasonable costs relating to such action. The Secretary shall from time-to-time notify the Contractor of the identity of other Medicare contractors with common subcontracts.

Clause XI

MODIFICATION OF SUBCONTRACT

(a) Neither this subcontract nor any lower tier subcontract under this subcontract shall be modified or amended, regardless of amount, without obtaining prior written approval of the Secretary if it provides for the performance of any of the functions contained in the Medicare agreement between the Contractor and the Secretary.

(b) If this subcontract does not fall within the purview of paragraph (a) of this clause, the Secretary's prior approval shall be obtained for any modification or amendment thereof where the estimated cost of such change or changes would result in an increase of the costs to Medicare in excess of fifty percent of the Contractor's threshold amount as provided in its contract.

(c) Before this subcontract is renewed or any option herein is exercised, the Secretary's approval shall be obtained, unless the Secretary has previously stipulated otherwise in writing.

Clause XII

REGULATIONS AND GENERAL INSTRUCTIONS

The Contractor is obliged under its contract with the Secretary to comply with all Regulations and General Instructions as the Secretary may from time-to-time prescribe for the administration of its contract. To the extent that such Regulations and General Instructions affects this subcontract, the Subcontractor shall also comply with such Regulations and General Instructions.

Clause XIII

PROHIBITION AGAINST BILLING SERVICES

The provisions of this clause are applicable to this subcontract if it provides for facilities management services or any electronic data processing which contemplates performance of an integral part of the Medicare claims process. However, such provisions do not apply if this subcontract is for the lease or purchase of equipment or supplies.

The Subcontractor (or a parent, subsidiary, or affiliated organization) shall not perform services for providers which involve (1) the preparation or completing of preliminary or initial cost reports, or (2) the allocation of expenses to provider cost centers and apportionment of such costs between Medicare beneficiary patients and other patients of the provider where such data may be used in the preparation of cost reports subsequently submitted to the Subcontractor for desk review and audit and which serve as the basis for determination of Medicare program payments by the Subcontractor. The Subcontractor (or a parent, subsidiary or affiliated organization) shall not perform, in any jurisdiction in which it is serving as a Subcontractor to a Medicare Contractor, billing services for a provider where billings by such providers are to be subsequently processed by the Subcontractor for Medicare payments. This does not preclude the Subcontractor from offering and operating an automated billing service (software and equipment) for a provider as long as operating such a billing service does not require the Subcontractor to describe or code the health-care services being billed.

SECTION III

This subcontract incorporates the following clauses by reference with the same force and effect as if they were given in full text. Upon request, the Secretary will make their full text available to the Subcontractor.

The clauses are applicable to this subcontract or lower tier subcontract to Medicare is $10,000 or higher, unless specifically exempted by applicable rules, regulations, or Executive Orders. The term "Contractor" as used therein shall mean the "Subcontractor."

FEDERAL ACQUISITION REGULATION

(48 CFR, CHAPTER 1) CLAUSES

52.222-26	*Equal Opportunity (April 1984)*
52.219-8	*Utilization of Small Business Concerns and Small Disadvantaged Business Concerns (April 1984)*
52.220-3	*Utilization of Labor Surplus Area Concerns (April 1984)*
52.220-4	*Labor Surplus Area Subcontracting Program (April 1984)*
52.222-21	*Certification of Nonsegregated Facilities (April 1984)*
52.222-35	*Affirmative Action for Special Disabled and Vietnam Era Veterans (April 1984)*
52.222-36	*Affirmative Action for Handicapped Workers (April 1984)*
3.502	*Fees or Kick-Backs By Subcontractors (Anti-Kickback Act) (41 U.S.C. 51-54) (April 1984)*
52.219-13	*Utilization of Women-Owned Small Businesses (April 1984)*
52.215-1	*Examination of Records by Comptroller General (April 1984)*

Medicare Financial Management Manual
Chapter 9 – Provider Statistical & Reimbursement Report

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10 – Provider Statistical and Reimbursement System
(Rev. 27, 12-19-03)

CMS provides each intermediary a standard Provider Statistical and Reimbursement System (PS&R) to interface with billing form CMS-1450. This system provides reports to be used in developing and auditing provider cost reports and related data accumulation operations. Providers also must use the reports in preparing cost reports, and must be able to explain any variances between the PS&R report and the cost report.

Systems user reference manuals and software are distributed centrally. Updates to the program are prepared and released as needed. Implement and operate the system in accordance with the following guidelines. The intermediary shall establish procedures to integrate provider FY data collected prior to PS&R implementation. *Additional information related to the PS&R reporting system can be found in the PS&R User's Guide.*

20 – Intermediary Use of PS&R System Reports in Cost Settlement Process
(Rev. 27, 12-19-03)

20.1 – Provider Summary Report
(Rev. 27, 12-19-03)

The contractor shall furnish each provider with year-to-date provider summary reports by the 120th day after the end of the provider's cost reporting period. (See §30.2 of this chapter for a description of the reports.) The provider may use the appropriate provider

summary reports to file the cost report. The provider summary report may be furnished at more frequent intervals upon mutual agreement by the contractor and the provider. *Furnish the PS&R reports on electronic media, when cost effective, or on paper. The provider is expected to make reasonable efforts to process electronic media. (See Chapter 8, §10.1 for additional information concerning the split of PS&R summary report data.)*

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 that is dated no earlier than 90 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 that is dated no earlier than 90 days prior to the NPR date.

20.2 – Payment Reconciliation Report

(Rev. 27, 12-19-03)

The payment reconciliation report provides detailed data that supports the provider summary report. The intermediary shall use this report to resolve discrepancies between the provider's data and the summary report.

30 – Description of Reports Available from Standard PS&R System

(Rev. 27, 12-19-03)

Two *types of* reports are produced from the PS&R system. The first consist of statistical reports showing claim activity. These can be used for accounting and audit purposes regarding provider remittance. They are the main output and purpose of the PS&R system. The second shows the results of processing and are used for operations control and monitoring of the flow of data through the PS&R system. They include error reports, table listings, and results of updates and systems messages from data center staff. They also provide a detailed audit trail of the data. They are explained in the table maintenance and file maintenance sections of the PS&R User Reference manual.

All reports produced from the PS&R system list a program ID and run date. The program ID is a unique number that identifies the program that produced the report. The run date shows the specific date that the report was produced. These fields are for informational purposes only in the event of possible problems.

Statistical reports produced are:

- Payment Reconciliation Report

- Provider Summary Report

- DRG Summary Report *(Optional)*

30.1 – Payment Reconciliation Report

(Rev. 27, 12-19-03)

This report shows in detail claims accepted by the PS&R system with totals by provider within report type. All claims processed by the PS&R system will be *reflected on* this report. It *can serve as an* audit trail for *claims* activities and for comparison to the summary report.

FREQUENCY: Upon request.

30.2 – Provider Summary Reports

(Rev. 27, 12-19-03)

Summarizes claim data and other information by revenue code required for cost report settlement and CMS reporting purposes. Time periods included on this report are specified by the user.

FREQUENCY: Upon request.

REPORT TYPES: A report is generated for each type. These report types are based on the first two digits of the Bill Type code on the provider's claim form (CMS-1450). Report claims which cannot be mapped to one of the report types *are shown* under "UNKNOWN REPORT TYPE."

Listed below are all known PS&R report types.

11A	*Inpatient – Part A (MSP-LCC)*	*Supplements report type 110.* *For providers on PIP (Part A) the interim payments included on the cost report will be adjusted by the MSP-LCC amounts.*

11I	*Inpatient – Part A Managed Care (MSP-LCC)*	*Supplements report type 118.* *For providers on PIP (Part A) the interim payments included on the cost report will be adjusted by the MSP-LCC amounts.*
11J	*Inpatient – PPS Interim Bills (MSP-LCC)*	*Supplements report type 119.* *For providers on PIP (Part A) the interim payments included on the cost report will be adjusted by the MSP-LCC amounts.*
11K	*Inpatient Rehab – PPS Interim Bills*	*Summarizes Inpatient Part A hospital services reimbursed under the Inpatient Rehabilitation Facility PPS payment system that have been billed on an interim basis (bill frequency code of 2 or 3).*
11R	*Inpatient Rehabilitation – Part A*	*Summarizes Inpatient Part A hospital services reimbursed under the Inpatient Rehabilitation Facility PPS payment system.*
110	Inpatient – Part A	*Summarizes Inpatient Part A hospital services. Includes services reimbursed under cost, TEFRA and Inpatient PPS payment systems.*
118	*Inpatient – Part A Managed Care*	*Summarizes services billed under Part A for Medicare managed care patients for purposes of receiving reimbursement for DGME and IME.*
119	*Inpatient – PPS Interim Bills*	*Summarizes Inpatient Part A hospital services reimbursed under the Inpatient PPS payment system that have been billed on an interim basis (bill frequency code of 2 or 3).*
12A	*Inpatient – Part B (MSP-LCC)*	*Supplements report type 120.* *For providers on PIP (Part A) the interim payments included on the cost report will be adjusted by the MSP-LCC amounts.*

12C	*Inpatient – Part B VAC (MSP-LCC)*	*Supplements report type 122.* *For providers on PIP (Part A) the interim payments included on the cost report will be adjusted by the MSP-LCC amounts.*
12F	*Inpatient – Part B Fee Reimbursed (MSP-LCC)*	*Supplements report type.* *For providers on PIP (Part A) the interim payments included on the cost report will be adjusted by the MSP-LCC amounts.*
12P	*Inpatient Part B OPPS*	*Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.*
12Z	*Ambulance Blend Effective 4/01/02*	*Summarizes hospital outpatient ambulance services reimbursed under the ambulance fee schedule blended payment, which is effective for services provided* *on/after April 1, 2002.*
120	Inpatient – Part B	*Accumulates data for services normally covered under Part A that have become covered under Part B. For reimbursement purposes, Inpatient Part B and Outpatient Part B are combined on the cost report.*
122	*Inpatient – Part B VAC*	*Accumulates data applicable to vaccine services reimbursed based on 100% of reasonable cost. Data on this report is used to complete the cost report.*
125	*Inpatient – Part B Fee Reimbursed*	*Shows covered charges and reimbursement by revenue code for fee reimbursed services (for patients who have exhausted Part A benefits).*
13A	*Outpatient – All Other (MSP-LCC)*	*Supplements report type 130.*
13B	*Outpatient – Renal (MSP-LCC)*	*Supplements report type 131.*
13C	*Outpatient – Part B 100% (MSP-LCC)*	*Supplements report type 132.*

13F	*Outpatient – Fee Reimbursed (MSP-LCC)*	*Supplements report type 135. Covered charges and reimbursement are shown by revenue code for fee reimbursed services. Data also represents MSP claims paid on Lower of Cost or Charges (LCC) and considered settled at the claim level.*
13G	*O/P Other Diag. & Fee Schedule After 9/90(MSP-LCC)*	*Supplements report type 136.*
13H	*O/P Other Diag. & Fee Schedule. Before 10/90(MSP-LCC)*	*Supplements report type 137.*
13I	*O/P Radiology & Fee Schedule After 9/89 (MSP-LCC)*	*Supplements report type 138.*
13J	*O/P Rad & Fee Sch Pre 10/89 Or After 12/90(MSP-LCC)*	*Supplements report type 139.*
13P	*Outpatient – OPPS*	*Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.*
13Z	*Ambulance Blend Effective 04/01/02*	*Summarizes hospital outpatient ambulance services reimbursed under the ambulance fee schedule blended payment, which is effective for services provided on/after April 1, 2002.*
130	Outpatient – All Other/Ambulance	*Summarizes hospital outpatient data reimbursed on a reasonable cost basis, for all services other than diagnostic (see 136), radiology (see 139) and ASC (see 831) services. Also summarizes laboratory services reimbursed on a fee schedule in a supplemental report.*
131	Outpatient – Renal	*Displays outpatient hospital ESRD service for services prior to April 1, 1990.*
132	Outpatient – Part B 100%	*Accumulates data applicable to vaccine services reimbursed based on 100% of reasonable cost. Data on this report is used to complete the cost report.*

135	Outpatient Fee Reimbursed	Shows covered charges and reimbursement by revenue code for fee reimbursed services (Hospital Outpatient setting).
136	O/P Other Diag. & Fee Schedule After 9/90	Summarizes all outpatient other diagnostic services reimbursed in part based on a fee schedule.
137	O/P Other Diag. & Fee Schedule Before 10/90	Summarizes all outpatient other diagnostic services reimbursed in part based on a fee schedule.
138	Outpatient Radiology & Fee Schedule After 9/89	Summarizes outpatient radiology services reimbursed based on a fee schedule.
139	O/P Rad & Fee Sch Pre 10/89 And/Or After 12/90	Summarizes outpatient radiology services reimbursed based on a fee schedule.
14A	Outpatient / Other (MSP-LCC)	Supplements report type 140.
14C	Outpatient/Other Vaccines (MSP-LCC)	Supplements report type 142. This report accumulates data applicable to vaccine services reimbursed based on 100% of reasonable cost. Data on this report is used to complete the cost report.
14F	Outpatient/Other Mammography (MSP-LCC)	Supplements report type 145.
14P	Outpatient/Other – OPPS	Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.
140	Outpatient/ Other – All Other	Summarizes hospital other Part B data (bill type 14x) reimbursed on a reasonable cost basis.
142	Vaccines	Accumulates data applicable to vaccine services reimbursed based on 100% of reasonable cost. Data on this report is used to complete the cost report.
145	Outpatient/Other Mammography/ Fee Reimbursed	Shows covered charges and reimbursement by revenue code for fee reimbursed services.
18A	Swing Bed (MSP-LCC)	Supplements report type 180.
180	Swing Bed	Summarizes Swing Bed hospital services. A supplement to this report accumulates data by RUG category.

21A	*SNF -Inpatient – Part A (MSP-LCC)*	*Supplements report type 210.*
210	SNF -Inpatient – Part A	*Summarizes SNF Inpatient – Part A services.*
22A	*SNF -Inpatient – Part B 100% (MSP-LCC)*	*Supplements report type 220.*
22C	*SNF – Inpatient – Part B 100% VAC (MSP-LCC)*	*Supplements report type 222.*
22F	*SNF-Inpatient – Fee Reimbursed (MSP-LCC)*	*Supplements report type 225. Covered charges and reimbursement are shown by revenue code for fee reimbursed services. Data also represents MSP claims paid on Lower of Cost or Charges (LCC) and considered settled at the claim level.*
22P	*SNF-Outpatient-OPPS (Condition Code 07 W/Cast/Splint/Ant)*	*Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.*
22Z	*Ambulance Blend effective 04/02/02*	*Summarizes skilled nursing facility, outpatient ambulance services reimbursed under the ambulance fee schedule blended payment, which is effective for services provided on/after April 1, 2002.*
220	SNF -Inpatient – Part B 100%	*Summarizes SNF Inpatient – Part B services.*
222	*SNF -Inpatient – Part B 100% VAC*	*Accumulates data applicable to vaccine services reimbursed based on 100% of reasonable cost. Data on this report is used to complete the cost report.*
225	*SNF -Inpatient – Fee Reimbursed*	*Shows covered charges and reimbursement by revenue code for fee reimbursed services.*
23A	*SNF – Outpatient (MSP-LCC)*	*Supplements report type 230.*
23C	*SNF – Outpatient VAC (MSP-LCC)*	*Supplements report type 232.*
23F	*SNF – Outpatient Fee Reimbursed (MSP-LCC)*	*Supplements report type 235. Covered charges and reimbursement are shown by revenue code for fee reimbursed services. Data also represents MSP claims paid on Lower of Cost or Charges (LCC) and considered settled at the claim level.*

23P	*SNF-Outpatient-OPPS (Condition Code 07 W/Cast/Splint/Ant)*	*Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.*
23Z	*Ambulance Blend effective 04/02/02*	*Summarizes skilled nursing facility, outpatient ambulance services reimbursed under the ambulance fee schedule blended payment, which is effective for services provided on/after April 1, 2002.*
230	SNF – Outpatient	*Summarizes SNF outpatient services.*
232	*SNF – Outpatient VAC.*	*Accumulates data applicable to vaccine services reimbursed based on 100% of reasonable cost. Data on this report is used to complete the cost report.*
235	*SNF – Outpatient Fee Reimbursed*	*Shows covered charges and reimbursement by revenue code for fee reimbursed services.*
24P	*SNF-Outpatient-OPPS (Condition Code 07 W/Cast/Splint/Ant)*	*Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.*
32C	*Home Health – (MSP-LCC)*	*OD44203 report number under report type 32A: Summarizes the Part B claims with a plan of treatment that are subject to MSP-LCC limitation. Services included on this report are typically not subject to deductible or coinsurance. Report was previously used in cost reports ending prior to October 1, 2000, and then only if the provider was reimbursed under PIP method.* *D45300 report number (which corresponds to the OD44203 report): Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 32A is NOT needed for cost reporting purposes.*
32M	*Home Health – (MSP-LCC)*	*Supplements report type 329.*

320	Home Health – Part B	*OD44203 report number under report type 320: Summarizes data included on home health Part B claims with a plan of treatment prior to implementation of home health PPS (October 1, 2000). Services included on this report are typically not subject to deductibles or coinsurance.* *OD45300 report number (which corresponds to the OD44203 report): Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 320 is NOT needed for cost reporting purposes.*
322	*Home Health – Part B*	*Summarizes Medicare Part B Requests for Anticipated Payments (RAPs) activity. The RAPs are not used in the cost report.*
329	*Home Health – Part B Episode*	*OD44203 report number under report type 329: Summarizes data included on Part B home health prospective payments episodes covered under a signed plan of treatment. Part B home health data is broken out into different episodic units. Services included on this report are typically not subject to deductibles or coinsurance.* *OD45300 report number (which corresponds to the OD44203 report): Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 329 is NOT needed for cost reporting purposes.*

33A	*Home Health – Part A (MSP-LCC)*	*OD44203 report number under report type 33A: Summarizes the Part A claims with a plan of treatment that is subject to MSP-LCC limitation. Services included on this report are typically not subject to deductible or coinsurance. Report was previously used in cost reports ending prior to October 1, 2000, and then only if the provider was reimbursed under PIP method.* *OD45300 report number (which corresponds to the OD44203 report):Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 33A is NOT needed for cost reporting purposes.*
33M	*Home Health – Part A (MSP-LCC)*	*Supplements report type 339.*
330	Home Health – Part	*OD44203 report number under report type 330: Summarizes data included on home health Part A claims with a plan of treatment prior to implementation of home health PPS (October 1 2000).* *OD45300 report number (which corresponds to the OD44203 report): Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 330 is NOT needed for cost reporting purposes.*
332	*Home Health – Part A*	*Summarizes Medicare Part A Requests for Anticipated Payments (RAPs) activity. The RAPs are not used in the cost report.*

339	*Home Health – Part A Episode*	*OD44203 report number under report type 339: Summarizes data included on Part A home health prospective payment episodes covered under a signed plan of treatment. Part A home health data is broken out into different episodic units.* *OD45300 report number (which corresponds to the OD44203 report): Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 339 is NOT needed for cost reporting purposes.*
34A	*Home Health – Part B (MSP-LCC)*	*Summarizes the Part B claims not under a plan of treatment that is subject to MSP-LCC limitation. Data found in this report are subject to coinsurance and deductible.*
34P	*HHA Outpatient-OPPS (Not Hhpps)*	*Summarizes the Part B claims data not under a signed plan of care that are reimbursed under Outpatient PPS. Used in cost reports prior to starting date of 10/1/00.*
340	Home Health – Part B. (w/o a plan of treatment)	*Summarizes data included on Part B claims without a signed plan of treatment. Services included on this report are typically subject to deductibles or coinsurance.*
342	*Home Health – Part B – Vaccine*	*Summarizes Part B vaccine claim data that is not reimbursed under OPPS.*
345	*Home Health – Part B – Rehab*	*Summarizes the Part B therapy claims data that was furnished on and after 1/1/99 and not under a signed plan of care.*
399	*Home Health – Part A And Part B Episode*	*Summarizes the home health episode data from the 329 Home Health Part B Episode report and the 339 Home Health Part A Episode report.*

410	Christian Science – Inpatient – Part A	*Summarizes the Medicare days, discharges, charges, deductibles, coinsurance and net reimbursement for a reporting period. Christian Science facilities typically have relatively low Medicare utilization and the majority of their charges are for routine inpatient care.*
71A	*Clinic – Rural Health (MSP-LCC)*	*Supplements report type 710.*
71C	*Clinic – Rural Health – 100% (MSP-LCC)*	*Supplements report type 712.*
71P	*Clinic-Rural Health-OPPS (Condition Code 07)*	*Captures data from all lines that were paid under OPPS including lines paid as ASC services packaged with them. Effective with services 8/1/00 and after.*
710	Clinic – Rural Health	*Summarizes data for rural health clinic services (bill type 71x) paid based on an all-inclusive rate.*
712	*Clinic – Rural Health – VAC*	*Summarizes vaccine services provided by rural health clinics.*
72A	Hosp. Based Or Ind. Renal Dialysis Center (MSP-LCC)	*Supplements report type 720.*
72C	Free Standing Renal Dialysis 100% – VAC (MSP-LCC)	*Supplements report type 722.*
720	Hosp. Based Or Independent. Renal Dialysis Center	*Summarizes data for renal dialysis centers (bill type 72x) paid based on an all-inclusive rate.*
722	*Free Standing Renal Dialysis 100% – VAC*	*Summarizes vaccine services provided by Free Standing Renal Dialysis centers.*
73A	*FQHC (MSP-LCC)*	*Supplements report type 730.*
73C	*FQHC-100% (MSP-LCC)*	*Supplements report type 732.*
73P	*FQHC-OPPS (Condition Code 07)*	*Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.*
730	FQHC	*Summarizes data for Federally Qualified Health Clinic services (bill type 73x) paid based on an all-inclusive rate.*
732	*FQHC-VAC*	*Summarizes vaccine services provided by FQHC facilities.*

74A	Rehabilitation Facility (MSP-LCC)	Supplements report type 740.
74C	Rehabilitation Facility-100% (MSP-LCC)	Supplements report type 742.
74F	Rehabilitation Facility-Fee Reimbursed (MSP-LCC)	Supplements report type 745.
74P	Rehabilitation Facility-OPPS (Condition Code 07)	Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.
740	Rehabilitation Facility	Shows cost reimbursed data, if any, by accommodation and ancillary service revenue codes. Captures lines of claims paid under the cost-reimbursed method for Outpatient Rehab facilities-mainly services prior to 1/1/99. This report is used to determine whether a provider has either Low Utilization or No Medicare Business for cost reporting. No cost report is required for reporting periods ending on or after July 1, 2003 [CMS Flash Report – dated May 9, 2003].
742	Rehabilitation Facility-VAC	Summarizes vaccine services provided by CORF facilities.
745	Rehabilitation Facility-Fee Reimbursed	Shows covered charges and reimbursement by revenue code for fee reimbursed services.
75A	CORF (MSP-LCC)	Supplements report type 750.
75C	CORF-100% (MSP-LCC)	Supplements report type 752.
75F	CORF-Fee Reimbursed (MSP-LCC)	Supplements report type 755. Covered charges and reimbursement are shown by revenue code for fee reimbursed services. Data also represents MSP claims paid on Lower of Cost or Charges (LCC) and considered settled at the claim level.
75P	CORF-OPPS	Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.

750	*CORF*	*Shows cost reimbursed data, if any, by accommodation and ancillary service revenue codes. Captures lines of claims paid under the cost-reimbursed method for Comprehensive Rehab Facilities mainly services prior to 1/1/99. This report is used to determine whether a provider has either Low Utilization or No Medicare Business for cost reporting.] No cost report is required for reporting periods ending on or after April 1, **2001** [CMS Flash Report – dated May 9, 2003].*
752	*CORF-VAC*	*Summarizes vaccine services provided by CORF facilities.*
755	*CORF-Fee Reimbursed*	*Shows covered charges and reimbursement by revenue code for fee reimbursed services.*
76A	*Community Mental Health Center (MSP-LCC)*	*Supplements report type 760.*
76C	*Community Mental Health Center-100% (MSP-LCC)*	*Supplements report type 762.*
76F	*Community Mental Health Center-Fee Reimbursement (MSP-LCC)*	*Supplements report type 765. Covered charges and reimbursement are shown by revenue code for fee reimbursed services. Data also represents MSP claims paid on Lower of Cost or Charges (LCC) and considered settled at the claim level.*
76P	*CMHC-OPPS*	*Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.*
760	*Community Mental Health Center*	*Captures lines of claims paid under the cost-reimbursed method for Community Health Centers – mainly services prior to 8/1/00.*
762	*Community Mental Health Center-VAC*	*Summarizes vaccine services provided by Community Health Centers.*
765	*Community Mental Health Center-Fee Reimbursed*	*Shows covered charges and reimbursement by revenue code for fee reimbursed services.*

81A	*Hospice – Non-Hospital Based (MSP-LCC)*	*OD44203 report number under report type 81A: Summarizes the Non-Hospital based (Free Standing) Hospice claims that are subject to MSP-LCC limitation.* *OD45300 report number (which corresponds to the OD44203 report): Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 81A is informational only.*
81P	*Hospice – Non-Hospital Based –OPPS (Condition Code 07)*	*Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.*
810	Hospice – Non-Hospital Based	*OD44203 report number under report type 810: Summarizes the Non-Hospital based (Free Standing) hospice claim data. May be used in cost report.* *OD45300 report number (which corresponds to the OD44203 report): Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 810 is informational only.*
82A	*Hospice – Hospital Based (MSP-LCC)*	*OD44203 report number under report type 82A: Summarizes the Hospital (provider) based Hospice claims that are subject to the MSP-LCC limitation. OD45300 report number (which corresponds to the OD44203 report): Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 82A is informational only.*
82P	*Hospice – Hospital Based-OPPS (Condition Code 07)*	*Captures data from all lines of a claim that were paid under OPPS including lines paid as APC services packaged with them. Effective with services 8/1/00 and after.*

820	Hospice – Hospital Based	*OD44203 report number under report type 820: Summarizes the Hospital (provider) based Hospice claim data. May be used in cost report.* *OD45300 report number (which corresponds to the OD44203 report): Summarizes visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 820 is informational only.*
83A	*ASC And ASC Fee Schedule (MSP-LCC)*	*Supplements report type 830.*
83B	*ASC And ASC Fee Schedule After 12/90 (MSP-LCC)*	*Supplements report type 831.*
830	ASC And ASC Fee Schedule	*Summarizes all outpatient ambulatory surgical services reimbursed in part based on HCPCS.*
831	*ASC And ASC Fee Schedule After 12/90*	*Summarizes all outpatient ambulatory surgical services reimbursed in part based on HCPCS.*
85A	*CAH (MSP-LCC)*	*Supplements report type 850.*
85C	*CAH-100% (MSP-LCC)*	*Supplements report type 852.*
85F	*CAH-Fee Reimbursed/Mammography (MSP-LCC)*	*Supplements report type 855. Covered charges and reimbursement are shown by revenue code for fee reimbursed services. Data also represents MSP claims paid on Lower of Cost or Charges (LCC) and considered settled at the claim level.*
85Z	*CAH Ambulance Blend Effective 04/01/02*	*Summarizes critical access hospital, outpatient ambulance services reimbursed under the fee schedule blended payment, which is effective for services provided on/after April 1, 2002.*
850	*CAH*	*Summarizes data for critical access hospital services (bill type 85x) reimbursed on a cost basis.*
852	*CAH-VAC*	*Summarizes vaccine services provided by critical access hospitals reimbursed on a reasonable cost basis.*
855	*CAH-Fee Reimbursed/Mammography*	*Shows covered charges and reimbursement by revenue code for fee reimbursed services.*

998	*Hospital Outpatient – Part B*	*Summarizes, by revenue code and report type, the information that is printed on the various outpatient report types. This report cannot be used to complete the cost report.*
999	*All Report Types For Provider*	*MSA/Beneficiary Census/Rev Visits report: Summarizes the visits and census per metropolitan statistical area (MSA). The OD45300 report number under report type 999 for Home Health Agencies is used for cost reporting periods ending before October 1, 2000* *The OD45300 report number under report type 999 for hospice providers is informational only.*
OD 44215	*DRG Summary Report*	*Summarizes PPS data by DRGs. It is optional and requested on demand.*

NOTE: In all cases other than outpatient, the report type ties directly to the type of bill entered on the claim (CMS-1450). For outpatient bills, the distinction is broken out further to identify the bills as All Other, Part B 100 percent, renal bills, and ASC.

30.3 – DRG Summary Report

(Rev. 27, 12-19-03)

This report for PPS is a supplement to the provider summary report and is *an optional report that is* produced *upon request* when a provider summary report is produced for any given provider. The report is a summary of prospective payment data broken out and summarized by DRG code.

40 – Corrections to Individual Records

(Rev. 27, 12-19-03)

The PS&R system allows corrections of total charges and/or units, days/visits, revenue codes within a provider and changes to covered amounts on the provider summary report. The following data are required to make adjustments.

INDIVIDUAL RECORDS

Item **Enter**

1.	Request Date	Today's Date
2.	Submitted By	Your Name
3.	Provider Number	The provider to be adjusted.
4.	Report Type	The report type of the provider to be adjusted.
5.	Paid Date	The remittance date for the claim(s) being adjusted.
6.	Thru Date	The thru date of service for the claim(s) being adjusted.
7.	DRG Code	For prospective payment providers, the DRG code under which the change was made. For other providers leave blank.
8.	Add to Revenue Code	The revenue code to receive the new amounts.
9.	Subtract from Revenue Code	The revenue code from where amounts should be subtracted.
10.	Days (Visits)	Number of days/visits to be adjusted between the revenue codes specified.
11.	Charges	Dollar amounts to be adjusted.

The PS&R system processes adjustments with a frequency code of 7 (cancel) and 8 (reissue). Other types of adjustments, e.g., credits and debits, PRO adjustments, cannot be handled by this system. Prepare an interface program that will convert the adjustments to frequency codes 7 or 8 in order to process PRO debit/credit adjustments and maintain the data in the PS&R system for cost settlement.

50 – The PS&R System Data Elements

(Rev. 27, 12-19-03)

Maintain the following data elements from the *FISS paid claim file.*

This sections contains a cross walk of data elements used in the FI paid claims file and the PS&R detail files. The cross walk is presented below. It contains the current FISS paid claim record and shows how it cross walks to the PS&R detail file.

Cross Walk of Data Elements in FI Paid Claims file and PS&R Detail File

FI Paid Claim File	*PS&R Detail Record File*	*Comments*
FSSCPDCL-NO	*C-DETL-HICAN*	
FSSCPDCL-NO	*C-DETL2-HICAN*	*Via C-DETL-HICAN*
FSSCPDCL-PAT-LAST-NM	*C-DETL-BENE-LNAME*	
FSSCPDCL-PAT-FIRST-NM	*C-DETL-BENE-INIT1*	
FSSCPDCL-PAT-FIRST-INIT	*C-DETL-BENE-INIT1*	
FSSCPDCL-PAT-MIDL-INIT	*C-DETL-BENE-INIT2*	
FSSCPDCL-PAT-LAST-NM	*C-2DETL-BENE-LNAME*	*Via C-BENE-LNAME*
FSSCPDCL-PAT-FIRST-NM	*C-2DETL-BENE-INIT1*	*Via C-BENE-INIT1*
FSSCPDCL-PAT-FIRST-INIT	*C-2DETL-BENE-INIT1*	*Via C-BENE-INIT1*
FSSCPDCL-PAT-MIDL-INIT	*C-2DETL-BENE-INIT2*	*Via C-BENE-INIT2*
FSSCPDCL-DCN	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-PLAN-CD	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-JULIAN	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-YR	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-JUL-DT	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-BTCH-NBR-X	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-BTCH-NBR	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-CLM-SEQ-NBR	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-SPLIT-CD	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-ORIG-CD	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-FUTURE	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-FUTURE2	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN-SITE-ID	*C-DETL-ICN*	*C-DETL-KEY*
FSSCPDCL-DCN	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-PLAN-CD	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-JULIAN	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-YR	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-JUL-DT	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-BTCH-NBR-X	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-BTCH-NBR	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-CLM-SEQ-NBR	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-SPLIT-CD	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-ORIG-CD	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-FUTURE	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-FUTURE2	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-DCN-SITE-ID	*C-DETL2-ICN*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-MEDA-PROV-ID	*C-DETL-PROV*	*C-DETL-KEY*
FSSCPDCL-PROV-STATE-CD	*C-DETL-PROV*	*C-DETL-KEY*
FSSCPDCL-PROV-ID	*C-DETL-PROV*	*C-DETL-KEY*
FSSCPDCL-PROV-TYP-FACIL-CD	*C-DETL-PROV*	*C-DETL-KEY*
FSSCPDCL-PROV-2	*C-DETL-PROV*	*C-DETL-KEY*
FSSCPDCL-PROV-EMER-IND	*C-DETL-PROV*	*C-DETL-KEY*
FSSCPDCL-PROV-DEPT-ID	*C-DETL-PROV*	*C-DETL-KEY*
FSSCPDCL-MEDA-PROV-FILLER	*C-DETL-PROV*	*C-DETL-KEY*
FSSCPDCL-MEDA-PROV-ID	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PROV-STATE-CD	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PROV-ID	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PROV-TYP-FACIL-CD	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PROV-2	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*

FI Paid Claim File	***PS&R Detail Record File***	***Comments***
FSSCPDCL-PROV-EMER-IND	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PROV-DEPT-ID	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-MEDA-PROV-FILLER	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-OTHER-SUMMARY-DATA	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-BILL-TYP-CD	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-BILL-CATEGORY	*C-DETL-RPT-TYPE*	*C-DETL-KEY*
FSSCPDCL-LOB-CD	*C-DETL-RPT-TYPE*	*C-DETL-KEY*
FSSCPDCL-SERV-TYP-CD	*C-DETL-RPT-TYPE*	*C-DETL-KEY*
88 PDCL-INP-CLAIM VALUES '11' '18 '21' '28' '33' '32' '41' '51' '81' '82'	*C-DETL-RPT-TYPE*	*C-DETL-KEY; COBOL condition name*
88 PDCL-HH-CLAIM VALUES '32' '81 '82'	*C-DETL-RPT-TYPE*	*C-DETL-KEY; COBOL condition name*
88 PDCL-HH-PPS-CLAIM VALUES '32' '33'	*C-DETL-RPT-TYPE*	*C-DETL-KEY; COBOL condition name*
88 PDCL-SNF-CLAIM VALUES '18' '21' '28'	*C-DETL-RPT-TYPE*	*C-DETL-KEY; COBOL condition name*
88 PDCL-OUTP-CLAIM VALUES '12' '13' '14''22' '23' '24' '34' '42' '43' '44' '52 '53' '54' '71' '72' '73' '74' '75' '76' '83' '85	*C-DETL-RPT-TYPE*	*C-DETL-KEY; COBOL condition name*
FSSCPDCL-FREQ-CD	*C-DETL-FREQ-CD*	*C-DETL-KEY (If I or P, make 7)*
FSSCPDCL-BILL-TYP-CD	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-BILL-CATEGORY	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-LOB-CD	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-SERV-TYP-CD	*C-DETL2-PROV*	*C-DETL2-KEY via C-DETL-KEY*
88 PDCL-INP-CLAIM VALUES '11' '18 '21' '28' '33' '32' '41' '51' '81' '82'	*C-DETL2-PROV*	*C-DETL2-KEY; COBOL condition name*
88 PDCL-HH-CLAIM VALUES '32' '81 '82'	*C-DETL2-PROV*	*C-DETL2-KEY; COBOL condition name*
88 PDCL-HH-PPS-CLAIM VALUES '32' '33'	*C-DETL2-PROV*	*C-DETL2-KEY; COBOL condition name*
88 PDCL-SNF-CLAIM VALUES '18' '21' '28'	*C-DETL2-PROV*	*C-DETL2-KEY; COBOL condition name*
88 PDCL-OUTP-CLAIM VALUES '12' '13' '14''22' '23' '24' '34' '42' '43' '44' '52 '53' '54' '71' '72' '73' '74' '75' '76' '83' '85	*C-DETL2-PROV*	*C-DETL2-KEY; COBOL condition name*
FSSCPDCL-FREQ-CD	*C-DETL2-PROV*	*C-DETL2-KEY (If I or P, make 7.) via C-DETL-KEY*
FSSCPDCL-FREQ-CD	*C-DETL-RPT-TYPE VIA W-RPT-CLASS*	*C-DETL-KEY*
88 PDCL-FINAL-BILL VALUES '1' '4' '5' '9'	*C-DETL-RPT-TYPE VIA W-RPT-CLASS*	*C-DETL-KEY; COBOL condition name*
88 PDCL-INTERIM-BILL VALUES '2' '3'	*C-DETL-RPT-TYPE VIA W-RPT-CLASS*	*C-DETL-KEY; COBOL condition name*
88 PDCL-NO-PAY-BILL VALUE '0'	*C-DETL-RPT-TYPE VIA W-RPT-CLASS*	*C-DETL-KEY; COBOL condition name*
88 PDCL-DEBIT-ADJ VALUE '7'	*C-DETL-RPT-TYPE VIA W-RPT-CLASS*	*C-DETL-KEY; COBOL condition name*
88 PDCL-CREDIT-ADJ VALUE '8'	*C-DETL-RPT-TYPE VIA W-RPT-CLASS*	*C-DETL-KEY; COBOL condition name*
88 PDCL-CANCEL-BILL VALUE '8' 'F 'G' 'H' 'I' 'J' 'K' 'M'	*C-DETL-RPT-TYPE VIA W-RPT-CLASS*	*C-DETL-KEY; COBOL condition name*
FSSCPDCL-RECD-DT-CYMD	*C-DETL-RECEIPT-DT*	

FI Paid Claim File	***PS&R Detail Record File***	***Comments***
FSSCPDCL-PAID-DT-CYMD	*C-DETL-RMT-DATE*	*C-DETL-KEY*
FSSCPDCL-PAID-DT-CC	*C-DETL-RMT-DATE*	*C-DETL-KEY*
FSSCPDCL-PAID-DT	*C-DETL-RMT-DATE*	*C-DETL-KEY*
FSSCPDCL-PAID-YR	*C-DETL-RMT-DATE*	*C-DETL-KEY via C-DETL-KEY*
FSSCPDCL-PAID-MO	*C-DETL-RMT-DATE*	*C-DETL-KEY*
FSSCPDCL-PAID-DY	*C-DETL-RMT-DATE*	*C-DETL-KEY*
FSSCPDCL-PAID-DT-CYMD	*C-DETL2-RMT-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PAID-DT-CC	*C-DETL2-RMT-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PAID-DT	*C-DETL2-RMT-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PAID-YR	*C-DETL2-RMT-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PAID-MO	*C-DETL2-RMT-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PAID-DY	*C-DETL2-RMT-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PAID-DT-CYMD	*C-DETL-FILE-DATE*	*C-DETL-KEY; MD400500*
FSSCPDCL-PAID-DT-CC	*C-DETL-FILE-DATE*	*C-DETL-KEY; MD400500*
FSSCPDCL-PAID-DT	*C-DETL-FILE-DATE*	*C-DETL-KEY; MD400500*
FSSCPDCL-PAID-YR	*C-DETL-FILE-DATE*	*C-DETL-KEY; MD400500*
FSSCPDCL-PAID-MO	*C-DETL-FILE-DATE*	*C-DETL-KEY; MD400500*
FSSCPDCL-PAID-DY	*C-DETL-FILE-DATE*	*C-DETL-KEY; MD400500*
FSSCPDCL-STMT-COV-FROM-DT-CYMD	*C-DETL-FROM-DATE*	
FSSCPDCL-STMT-COV-FROM-DT-CC	*C-DETL-FROM-DATE*	
FSSCPDCL-STMT-COV-FROM-DT	*C-DETL-FROM-DATE*	
FSSCPDCL-STMT-COV-FROM-YR	*C-DETL-FROM-DATE*	
FSSCPDCL-STMT-COV-FROM-MO	*C-DETL-FROM-DATE*	
FSSCPDCL-STMT-COV-FROM-DY	*C-DETL-FROM-DATE*	
FSSCPDCL-STMT-COV-FROM-DT-CYMD	*C-DETL2-FROM-DATE*	*Via C-DETL-FROM-DATE*
FSSCPDCL-STMT-COV-FROM-DT-CC	*C-DETL2-FROM-DATE*	*Via C-DETL-FROM-DATE*
FSSCPDCL-STMT-COV-FROM-DT	*C-DETL2-FROM-DATE*	*Via C-DETL-FROM-DATE*
FSSCPDCL-STMT-COV-FROM-YR	*C-DETL2-FROM-DATE*	*Via C-DETL-FROM-DATE*
FSSCPDCL-STMT-COV-FROM-MO	*C-DETL2-FROM-DATE*	*Via C-DETL-FROM-DATE*
FSSCPDCL-STMT-COV-FROM-DY	*C-DETL2-FROM-DATE*	*Via C-DETL-FROM-DATE*
FSSCPDCL-STMT-COV-TO-DT-CYMD	*C-DETL-THRU-DATE*	*C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-DT-CC	*C-DETL-THRU-DATE*	*C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-DT	*C-DETL-THRU-DATE*	*C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-YR	*C-DETL-THRU-DATE*	*C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-MO	*C-DETL-THRU-DATE*	*C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-DY	*C-DETL-THRU-DATE*	*C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-DT-CYMD	*C-DETL2-THRU-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-DT-CC	*C-DETL2-THRU-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-DT	*C-DETL2-THRU-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-YR	*C-DETL2-THRU-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-MO	*C-DETL2-THRU-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-STMT-COV-TO-DY	*C-DETL2-THRU-DATE*	*C-DETL2-KEY via C-DETL-KEY*
FSSCPDCL-PAT-MED-REC-NO	*C-DETL-PCN*	
FSSCPDCL-DRG-CD	*C-DETL-DRG-CODE*	
FSSCPDCL-CANC-ADJ-CD	*C-DETL-CANCEL-ADJ*	
FSSCPDCL-MEDICAL-RECORD-NO	*C-DETL-PCN*	

FI Paid Claim File	PS&R Detail Record File	Comments
FSSCPDCL-PIP-IND	C-DETL-PIP-IND	In MD400600: IF FSSCPDCL-PIP-IND = 'Y' MOVE 'Y' TO C-DETL-PIP-IND
FSSCPDCL-HH-SPLIT-IND	C-DETL-HH-SPLIT-IND	
FSSCPDCL-PATIENT-STATUS	C-DETL-PAT-STATUS	
FSSCPDCL-PATIENT-STATUS	C-DETL2-PAT-STATUS	Via C-DETL-PAT-STATUS
FSSCPDCL-PATIENT-STATUS	C-DETL-PATIENT-ST	
FSSCPDCL-COV-DY-CNT	C-DETL-TRANS-DAYS	
FSSCPDCL-FED-PORTION	C-DETL-FED-SPEC-PMT	
FSSCPDCL-PPS-PAYMENT	C-DETL2-PPS-PAYMENT	
FSSCPDCL-DRG-WEIGHT	C-DETL-CAP-DRG-WT	
FSSCPDCL-DSCHG-FRCTN	C-DETL-CAP-DSCHG-FR	
FSSCPDCL-DRG-WT-FRCTN	C-DETL-DRGWT-FR	
FSSCPDCL-CAP-TOT-PAY	C-DETL-CAPTL-PMT	C-DETL-CAPTL-PMT redefines C-DETL-ESRD-NETWORK
FSSCPDCL-CAP-FSP	C-DETL-CAP-FSP	
FSSCPDCL-CAP-DSH-ADJ	C-DETL-CAP-DSH-ADJ	
FSSCPDCL-CAP2-B-FSP	C-DETL-CAP-B-FSP	
FSSCPDCL-CAP-HSP	C-DETL-CAP-HSP	
FSSCPDCL-CAP-OLD-HARM	C-DETL-CAP-OLD-HARM	
FSSCPDCL-CAP-IME-ADJ	C-DETL-CAP-IME-ADJ	
FSSCPDCL-PPS-RTC	C-DETL-PRICER-RTC	
FSSCPDCL-COIN-DAYS-1ST-YR	C-DETL-COIN-DAYS	
FSSCPDCL-CAP-OUTLIER	C-DETL-CAP-OUTLIER	
FSSCPDCL-CAP2-B-OUTLIER	C-DETL-CAP-B-OUTLIE	
FSSCPDCL-OUTLIER-DYS	C-DETL-OUTLIER-DAYS	
FSSCPDCL-HOSP-PORTION	C-DETL-HOS-SPEC-PMT	
FSSCPDCL-CAPI-EXCEPTIONS	C-DETL-CAP-EXCPTONS	
FSSCPDCL-VAL-AMT	C-DETL-CASH-DEDUCT	Via W-VALUE-AMT-9 in MD400600
FSSCPDCL-VAL-AMT	C-DETL-CASH-DEDUCT	Via W-0-CASH-DEDUCT in MD400700
FSSCPDCL-VAL-AMT	C-DETL-CASH-DEDUCT	Via W-0-CASH-DEDUCT in MD400701
FSSCPDCL-VAL-AMT	C-DETL-CASH-DEDUCT	Via W-0-CASH-DEDUCT in MD400710
FSSCPDCL-VAL-AMT	C-DETL-CASH-DEDUCT	Via W-DEDUCTIBLE via W-O-CASH-DEDUCT in MD400700
FSSCPDCL-VAL-AMT	C-DETL-CASH-DEDUCT	Via W-DEDUCTIBLE via W-O-CASH-DEDUCT in MD400701
FSSCPDCL-VAL-AMT	C-DETL-CASH-DEDUCT	Via W-DEDUCTIBLE via W-O-CASH-DEDUCT in MD400710
FSSCPDCL-VAL-AMT	C-DETL-SRVC-MSAE	Field is set in this portion of MD400600: MSAE-RTN IF W-VALUE-AMT (3:3) = '099' MOVE W-VALUE-AMT (6:2) TO C-DETL-SRVC-MSAE (3:2) ELSE IF W-VALUE-AMT (3:2) = '99' MOVE W-VALUE-AMT (5:3) TO C-DETL-SRVC-MSAE (3:3) ELSE IF W-VALUE-AMT (7:1) > '5' MOVE W-VALUE-AMT (3:5) TO C-DETL-SRVC-MSAE ELSE

FI Paid Claim File	*PS&R Detail Record File*	*Comments*
		MOVE W-VALUE-AMT (4:4) TO C-DETL-SRVC-MSAE. *MSAE-RTN-EXIT* *EXIT*
FSSCPDCL-REIMB-PROV-AMT	*C-DETL-NET-REIMB*	
FSSCPDCL-REIMB-PROV-AMT	*C-DETL-TRANS-PMT*	*C-DETL-TRANS-PMT = FSSCPDCL-REIMB-PROV-AMT - W-OUT-EIMB-AMT*
FSSCPDCL-HCPC-CD-X	*C-DETL-HCPCS-CD*	*Via W-DETL-HCPCS-TRL.W-DETL-HCPCS-CD via W-HCPCS-CD in MD400600*
FSSCPDCL-HCPC-MODIFIERS	*C-DETL-ASC-HCPCMODS*	*Via W-DETL-HCPCS-MODS via W-HCPCS-MODIFIERS in MD400600*
FSSCPDCL-HCPC-MODIFIER	*C-DETL-ASC-HCPCMODS*	*Via W-DETL-HCPCS-MODS via W-HCPCS-MODIFIERS in MD400600*
FSSCPDCL-HCPC-MODIFIER2	*C-DETL-ASC-HCPCMODS*	*Via W-DETL-HCPCS-MODS via W-HCPCS-MODIFIERS in MD400600*
FSSCPDCL-HCPC-MODIFIER3	*C-DETL-ASC-HCPCMODS*	*Via W-DETL-HCPCS-MODS via W-HCPCS-MODIFIERS in MD400600*
FSSCPDCL-HCPC-MODIFIER4	*C-DETL-ASC-HCPCMODS*	*Via W-DETL-HCPCS-MODS via W-HCPCS-MODIFIERS in MD400600*
FSSCPDCL-HCPC-MODIFIER5	*C-DETL-ASC-HCPCMODS*	*Via W-DETL-HCPCS-MODS via W-HCPCS-MODIFIERS in MD400600*
FSSCPDCL-ASC-PERCENT	*C-DETL-ASC-PCT-IND*	*Via W-ASC-TRL.WAT-PCT-IND via W-ASCC-PERCENT in MD400600*
FSSCPDCL-ASC-GRP	*C-DETL-ASC-GRP-CD*	*Via W-ASC-TRL.WAT-GRP-CD via W-ASC-GROUP in MD400600*
FSSCPDCL-PRICER-IND	*C-DETL2-PRICER-IND*	
FSSCPDCL-OPPS-PRICR-LINE-RTC	*C-DETL2-PRICER-LINE-RTC*	
FSSCPDCL-REV-CD	*C-DETL-HCPCS-REV*	*Via W-HCPCS-TRL.W-DETL-HCPCS-REV via W-REVENUE-CD in MD400600*
FSSCPDCL-REV-CD	*C-DETL-REV-CD*	*Via W-DETL-REV-CD via W-REVENUE-CD in MD400600.*
88 FSSCPDCL-FEE-SCHEDULE-REV CD VALUES 0274, 0300 THRU 0319, 0403	*C-DETL-REV-CD*	*COBOL condition name*
88 PDCL-FEE-SCHEDULE-REV-CD VALUES 0274, 0300 THRU 0319, 0403	*C-DETL-REV-CD*	*COBOL condition name*
FSSCPDCL-REV-CD-X redefines FSSCPDCL-REV-CD	*C-DETL-REV-CD*	
FSSCPDCL-REV-SERV-UNIT-CNT PIC 9(07)	*C-DETL-HCPCS-UNITS*	*Via W-HCPCS-TRL.W-DETL-HCPCS-UNITS via W-UNITS in MD400600*
FSSCPDCL-REV-SERV-UNIT-CNT PIC 9(07)	*C-DETL-REV-UNITS*	*Via W-DETL-REV-UNITS via W-UNITS in MD400600*
FSSCPDCL-REV-SERV-RATE	*C-DETL-HCPCS-REIMB*	*Via W-RATE in MD400600*
FSSCPDCL-RAD-PRICER-AMT-X		
FSSCPDCL-RAD-PRICER-AMT	*C-DETL-HCPCS-REIMB*	*Via W-RATE via W-RAD-PRICER-AMT in MD400600*
FSSCPDCL-RAD-PRICER-AMT	*C-DETL2-APC-GROSS-PMT*	*Via W-RATE via W-RAD-PRICER-AMT in MD400600*
FSSCPDCL-REV-TOT-CHRG-AMT	*C-DETL-REV-CHG*	*Via W-DETL-REV-CHG via W-SERV-CHARGES in MD400600*
FSSCPDCL-REV-TOT-CHRG-AMT	*C-DETL-TOT-COV-CHG*	*Via W-DETL-REV-CHRG via W-SERV-CHARGES*

FI Paid Claim File	***PS&R Detail Record File***	***Comments***
FSSCPDCL-REV-COV-CHRG-AMT	*C-DETL-HCPCS-REIMB*	*Via W-RATE in MD400600*
FSSCPDCL-REV-COV-CHRG-AMT	*C-DETL2-REV-COV-CHG-AMT*	
FSSCPDCL-REV-TOT-CHRG-AMT	*C-DETL-TOT-COV-CHG*	*Via W-DETL-REV-CHRG via W-SERV-CHARGES*
FSSCPDCL-REV-COV-CHRG-AMT	*C-DETL-REV-CHG*	*Via W-DETL-REV-CHG via W-SERV-CHARGES in MD400600*
FSSCPDCL-REV-NCOV-CHRG-AMT	*C-DETL-REV-CHG*	*Via W-RATE via W-I-SERV-NCOV-CHARGES in MD400600*
FSSCPDCL-REV-NCOV-CHRG-AMT	*C-DETL-HCPCS-REIMB*	*Via W-RATE via W-I-SERV-NCOV-CHARGES in MD400600*
FSSCPDCL-REV-TOT-CHRG-AMT	*C-DETL-HCPCS-BLDCHG*	*Via W-DETL-REV-CHG via W-SERV-CHARGES in MD400600*
FSSCPDCL-REV-COV-CHRG-AMT	*C-DETL-HCPCS-BLDCHG*	*Via W-DETL-REV-CHG via W-SERV-CHARGES in MD400600*
FSSCPDCL-REV-NCOV-CHRG-AMT	*C-DETL-HCPCS-BLDCHG*	*Via W-RATE via W-I-SERV-NCOV-CHARGES in MD400600*
FSSCPDCL-WAGE-ADJ-COIN-LINE	*C-DETL2-WGE-ADJ-COIN-LINE*	
FSSCPDCL-REDUCED-COIN-LINE	*C-DETL2-REDU-COIN-LINE*	
FSSCPDCL-PROV-REIMB-LINE	*C-DETL2-PROV-REIMB-LINE*	
FSSCPDCL-PAT-CASH-DED-LINE	*C-DETL2-PAT-CASH-DED-LINE*	
FSSCPDCL-PSY-ESRD-BLD-HEMO	*C-DETL2-PSY-ESRD-BLD-HEMO*	
FSSCPDCL-APC-HCPCS-PROC	*C-DETL2-APC-HCPCS-PROC*	
FSSCPDCL-APC-SERV-IND	*C-DETL-APC-SERV-IND*	*Via W-DETL-REV-TRL.W-DETL-APC-SERV-IND via W-APC-SERV-IND in MD400600*
FSSCPDCL-APC-SERV-IND	*C-DETL2-APC-SERV-IND*	*Via W-DETL-REV-TRL.W-DETL-APC-SERV-IND via W-APC-SERV-IND in MD400600*
FSSCPDCL-SITE-OF-SERV-INC-FLAG redefines FSSCPDCL-APC-SERV-IND	*C-DETL-APC-SERV-IND*	*Via W-DETL-REV-TRL.W-DETL-APC-SERV-IND via W-APC-SERV-IND in MD400600*
FSSCPDCL-APC-PAYMENT-IND	*C-DETL2-APC-PMT-IND*	
FSSCPDCL-APC-DISC-FCTR	*C-DETL2-APC-DISC-FCTR*	
FSSCPDCL-APC-DEN-REJ	*C-DETL2-APC-DEN-REJ*	
FSSCPDCL-APC-PKG-FLAG	*C-DETL2-APC-PKG-FLAG*	
FSSCPDCL-APC-PAY-ADJ-FLAG	*C-DETL2-APC-PAY-ADJ-FLG*	
FSSCPDCL-APC-TOB-INCL	*C-DETL2-APC-TOB-INCL*	
FSSCPDCL-APC-ACTION-FLAG	*C-DETL2-APC-ACTION-FLAG*	
FSSCPDCL-ORIG-HCPC-CD	*C-DETL2-ORIG-HCPC-CD*	
FSSCPDCL-ORIG-HCPC-IND	*C-DETL2-ORIG-HCPC-IND*	
FSSCPDCL-HH-HRG-WGTS	*C-DETL-HIPPS-WGT*	*Via W-DETL-REV-TRL.W-DETL-HIPPS-WGT via W-HIPPS-WGT in MD400600*
FSSCPDCL-LINES-FUTURE3 PIC X(22)	*C-DETL-HIPPS-APC*	*Via W-DETL-REV-TRL.W-DETL-HIPPS-APC via W-HIPPS-APC via WS-HOLD-HIPPS via WS-FUTURE.W-HCPC in MD400600*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-SORT-BYTE*	*1 or 2; set in MD400600*
FSSCPDCL-VAL-AMT	*C-DETL-IND-MDED-PMT*	*Via W-MED-ED-PMT*

FI Paid Claim File	*PS&R Detail Record File*	*Comments*
FSSCPDCL-DRG-REIMB-AMT	*C-DETL-ASCPRICE-AMT*	*Via W-ASC-PRICE-AMT in MD400700*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-SEC-LIAB-PMT*	*Computed in MD400600*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-SEC-LIAB-PMT*	*Computed in MD400502*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-MSP-RED-IND*	*Via W-MSP-REDUCED-IND set in REDUCE-MSP procedure in MD400700*
	C-DETL-BLOOD-DEDUCT	*Via W-VALUE-AMT-9*
	C-DETL-VAL62	*Via W-VALUE-AMT-9*
	C-DETL-VAL63	*Via W-VALUE-AMT-9*
	C-DETL-VAL64	*Via W-VALUE-AMT-9*
	C-DETL-VAL65	*Via W-VALUE-AMT-9*
	C-DETL-DSH-PMT	*Via W-VALUE-AMT-9*
	C-DETL-INTEREST-PMT	*Via W-VALUE-AMT-9*
	C-DETL-ESRD-NETWORK	*Via W-VALUE-AMT-9*
	C-DETL-SEQ-AMT	*Via W-VALUE-AMT-9*
	C-DETL-FEE-MSP	*Via W-VALUE-AMT-9*
	C-DETL-FEE-SEQ	*Via W-VALUE-AMT-9*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-NPI*	*Field is not referenced by any programs*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL2-NPI*	*C-DETL2-KEY via C-DETL-KEY*
	C-DETL-LIFE-DAYS	*Via W-LR-DAY-TOT in MD400600; see W-LR-DAY-TOT in this crosswalk.*
	C-DETL-COINSURANCE	*Via W-O-COINSURANCE*
FSSCPDCL-PATIENT-STATUS	*C-DETL-BNFT-EXH-IND*	*In MD400600:* *IF FSSCPDCL-PATIENT-STATUS = '30' MOVE 'S' TO C-DETL-BNFT-EXH-IND*
	C-DETL-TOT-COV-CHG	
	C-DETL-OUT-DAYS-PMT	*Via W-OUT-REIMB-AMT*
	W-OUT-REIMB-AMT	*Via W-OUT-REIMB-AMT*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-TRANS-PMT*	*IF W-OUT-REIMB = 'Y' AND W-OUT-TYPE = 'C'* *COMPUTE C-DETL-TRANS-PMT =* *FSSCPDCL-REIMB-PROV-AMT -* *W-OUT-REIMB-AMT* *ELSE* *COMPUTE C-DETL-TRANS-PMT =* *FSSCPDCL-REIMB-PROV-AMT.*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-HCPC-TOTREIM*	
	C-DETL-HCPC-TOT-CHG	*ADD W-DETL-HCPCS-BLDCHG TO C-DETL-HCPC-TOT-CHG*
	C-DETL-HH-DME-COINS	*Redefines C-DETL-ASCPRICE-AMT and is not used in MD400600. Used in MD400502 and MD400501*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-ICN-IND*	*MOVE 'I' TO C-DETL-ICN-IND appears to be the only reference to this field in MD400600*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-GROSSUP-IND*	*IF (C-DETL-THRU-DATE (1:4) = '1992' OR '1993') AND* *(C-DETL-GROSSUP-IND NOT = 'G') AND* *(C-DETL-RPT-TYPE = '136' OR '137' OR '138' OR '139')* *PERFORM GROSSUP-CHECK* *MOVE 'G' TO C-DETL-GROSSUP-IND.*

FI Paid Claim File	PS&R Detail Record File	Comments
NO IDENTIFIABLE FIELD IN PCR	C-DETL-FEE-RED-IND	C-DETL-FEE-RED-IND is not referenced in MD400600. Set to 'Y' in M400502.
NO IDENTIFIABLE FIELD IN PCR	C-DETL-ORIG-THRU-CT	The only reference to this field in MD400600 is this statement: IF C-DETL-THRU-DATE = C-PDTE-START (W-SUB) MOVE 1 TO C-DETL-ORIG-THRU-CT MOVE C-DETL-THRU-DATE TO C-DETL-ORIG-THRU-DATE (1) SUBTRACT 1 FROM W-SUB MOVE C-PROV-PD-END (W-SUB) TO C-DETL-THRU-DATE MOVE 2 TO W-SUB.
NO IDENTIFIABLE FIELD IN PCR	C-DETL-SPLIT-CT	The sole apparent use of this field in MD400600 occurs here: SPLIT-RTN. IF W-SPLIT-TYPE (W-SUB) NOT = SPACES ADD 1 TO C-DETL-SPLIT-CT MOVE W-SPLIT-TYPE (W-SUB) TO C-DETL-SPLIT-IND (C-DETL-SPLIT-CT) SPLIT-RTN-EXIT. EXIT.
NO IDENTIFIABLE FIELD IN PCR	C-DETL-REV-TRL-CT	C-DETL-REV-TRL-CT is an index, used in the context of this statement in MD400600: MOVE W-DETL-REV-TRL TO C-DETL-REV-TRL (C-DETL-REV-TRL-CT)
NO IDENTIFIABLE FIELD IN PCR	C-DETL-HCPCS-TRL-CT	IF W-ASC-PRICE-AMT > MOVE W-DETL-HCPCS-TRL TO C-DETL-HCPCS-TRL (C-DETL-HCPCS-TRL-CT)
NO IDENTIFIABLE FIELD IN PCR	C-DETL-OPPS-GEN-IND	Field is set in this portion of MD400600: IF W-OPPS-CLAIM = 'Y' OR W-OCEFLG1-N = 'Y' OR (FSSCPDCL-STMT-COV-FROM-DT-CYMD > '20000731' AND (PDCL-OUTP-CLAIM AND (W-BILL-TYPE72X-SW NOT = 'Y') AND (FSSCPDCL-PAID-DT-CYMD > '20000611'))) MOVE 'Y' TO C-DETL-OPPS-GEN-IND.
NO IDENTIFIABLE FIELD IN PCR	C-DETL-ORIG-THRU-DATE	Field is set in this portion of MD400600: ORIG-THRU-RTN. IF C-DETL-THRU-DATE = C-PDTE-START (W-SUB) MOVE 1 TO C-DETL-ORIG-THRU-CT MOVE C-DETL-THRU-DATE TO C-DETL-ORIG-THRU-DATE (1) SUBTRACT 1 FROM W-SUB

FI Paid Claim File	*PS&R Detail Record File*	*Comments*
		MOVE C-PROV-PD-END (W-SUB) TO C-DETL-THRU-DATE *MOVE 2 TO W-SUB.* *ORIG-THRU-RTN-EXIT.* *EXIT.*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-SPLIT-IND*	*Field is set in this portion of MD400600:* *SPLIT-RTN.* *IF W-SPLIT-TYPE (W-SUB) NOT = SPACES* *ADD 1 TO C-DETL-SPLIT-CT* *MOVE W-SPLIT-TYPE (W-SUB) TO* *C-DETL-SPLIT-IND (C-DETL-SPLIT-CT)* *SPLIT-RTN-EXIT.* *EXIT.*
NO IDENTIFIABLE FIELD IN PCR	*W-NCOV-UNITS*	*IF W-UNITS > 0* *COMPUTE W-UNIT-CHG = W-SERV-CHARGES / W-UNITS* *COMPUTE W-COV-UNITS = W-COV-CHG / W-UNIT-CHG* *COMPUTE W-NCOV-UNITS = W-I-SERV-NCOV-CHARGES / W-UNIT-CHG.*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-REV-NCV-IND*	*Set via W-DETL-REV-NCV-IND via program logic.*
NO IDENTIFIABLE FIELD IN PCR	*W-LR-DAYS-TOT*	*COMPUTE W-LR-DAYS-TOT =* *(FSSCPDCL-LIFE-DY-CNT + FSSCPDCL-LTR-DAYS-2ND-YR).*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-FULL-DAYS*	*IF FSSCPDCL-CST-REP-DYS > 0 OR (W-SEC-LIAB = 'R' OR 'Y')* *COMPUTE C-DETL-FULL-DAYS = FSSCPDCL-CST-REP-DYS -* *FSSCPDCL-COIN-DAYS-1ST-YR - W-LR-DAYS-TOT* *ELSE* *COMPUTE C-DETL-FULL-DAYS = FSSCPDCL-COV-DY-CNT -* *FSSCPDCL-COIN-DAYS-1ST-YR – W-LR-DAYS-TOT.*
W-ASC-TRL	*C-DETL-ASC-TRL*	*See the 2 constituent fields in this structure: C-DETL-ASC-GRP-CD and C-DELT-ASC-PCT-IND*
	C-DETL-CAP-TRL	*See the 13 constituent fields in this structure*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-FREE-BYTES*	
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-FREE-BYTE*	
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-FREE-BYTE-CT*	
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-CAP-TRL-CT*	*Set to zero and incremented in MD400600*
	C-DETL-OUT-COST-PMT	*Via W-OUT-REIMB-AMT in MD400600*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-ASC-TRL-CT*	*Set to zero and incremented in MD400600*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-VAL-AMT*	*Via W-VALUE-AMT-9 in MD400600*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-VAL-CNT*	*Set to zero and incremented in MD400600*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-CLM-NCV-IND*	
NO IDENTIFIABLE FIELD IN PCR	*C-DETL-GROSS-APC*	*Set to zero only in MD400600*
	C-DETL-VAL64	*Via W-VALUE-AMT-9*

FI Paid Claim File	***PS&R Detail Record File***	***Comments***
	C-DETL-VAL65	*Via W-VALUE-AMT-9*
	C-DETL2-FREQ-CD	*C-DETL2-KEY via C-DETL-KEY*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL2-SORT-BYTE*	*C-DETL2-KEY via C-DETL-KEY; then set to '2*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL2-OPPS-TRL-CT*	*Via C-DETL-HCPCS-TRL-CT*
NO IDENTIFIABLE FIELD IN PCR	*C-DETL2-OPPS-TRL*	*Container of recurring structures containing:* *C-DETL2-APC-HCPCS-PROC* *C-DETL2-APC-PMT-APC* *C-DETL2-PRICER-LINE-RTC* *C-DETL2-PRICER-IND* *C-DETL2-APC-ACTION-FLAG* *C-DETL2-APC-GROSS-PMT* *C-DETL2-PROV-REIMB-LINE* *C-DETL2-APC-SERV-IND* *C-DETL2-APC-TOB-INCL* *C-DETL2-APC-PMT-IND* *C-DETL2-APC-DISC-FCTR* *C-DETL2-APC-DEN-REJ* *C-DETL2-APC-PKG-FLAG* *C-DETL2-APC-PAY-ADJ-FLG* *C-DETL2-REV-COV-CHG-AMT* *C-DETL2-REDU-COIN-LINE* *C-DETL2-WGE-ADJ-COIN-LINE* *C-DETL2-PSY-ESRD-BLD-HEMO* *C-DETL2-PAT-CASH-DED-LINE* *C-DETL2-ORIG-HCPC-CD* *C-DETL2-ORIG-HCPC-IND*