CMS Medicare Manual System
Pub. 100-6 Financial Management

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

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CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
9		Entire Chapter	

CLARIFICATION - EFFECTIVE/IMPLEMENTATION DATE: Not Applicable.

Medicare contractors only: these instructions should be implemented within your current operating budget.

This transmittal includes chapter 9 of the restructured Medicare Financial Management Manual.

The completed manual includes ten chapters containing all CMS instructions to carriers and intermediaries about CMS requirements described in the table below. This material was derived from the source material as shown in the last column.

While this revision updates and reorganizes text from current manuals, it includes no new procedures. All instructions in this chapter apply to intermediaries only.

This manual is designed primarily for display on the Internet. The following changes from past paper manual protocols are used as a result of the Internet environment.

- Redline - It is not possible to place a vertical bar in the left margin on Internet documents. Therefore changed text is identified by red, italic font. Note that redline is not used on this initial transmittal because all the text is new.

- Displaying change dates - The date and revision number for the last change in the section or subsection is shown after each section/subsection heading instead of at the bottom of the page.

- Page numbers - are not applicable for Internet documents.

- Distribution of printed copies is discontinued.

Also for the initial issuance a cross-reference is placed after each section heading to identify the source from where the material originated. This will be eliminated as subsequent transmittals replacing the same sections are released.

As the ten chapters are distributed the current financial instructions in PMs and the Carrier and Intermediary Manuals will be deleted.

Chapter	Chapter Title	Source
1	Budget Preparation	MIM-1, Chapters 1, 2, & 6 MCM-1, Chapters 1, 2, & 6
2	Budget Execution	MIM-1, Chapter 3 and 5 MCM-1, Chapter 3 and 5
3	Overpayments	MIM-2, Chapter 3, MIM-3, Chapter 8 MCM-3, Chapter 7
4	Debt Collection	MIM-2, Chapter 3 MCM-3, Chapter 7
5	Financial Reporting	MIM-1, Chapters 4 & 9 MCM-1, Chapters 4 & 9
6	Workload Reporting	MIM-3, Chapter 9 MCM-3, Chapter 13
7	Internal Control Requirements	New Material Issued With This Manual (CR 2231)
8	General Audit Guidelines	MIM-2, Chapter 1, MIM-4, Chapter 1
9	Intermediary Procedures for Provider Audits	MIM-4, Chapter 2
10	Provider Statistical & Reimbursement Report	MIM-2, Chapter 3

MIM = Medicare Intermediary Manual, CMS Pub 13, e.g., MIM-1 is Part 1 of CMS Pub 13

MCM = Medicare Carrier Manual, CMS Pub 14, e.g., MCM-2 is Part 2 of CMS Pub 14

Medicare Financial Management Manual

Chapter 9 - Intermediary Procedures for Provider Audits

Table of Contents

NOTE: Revision 9, the initial release of this chapter, includes a cross reference to the source sections in current manuals. A4 is the identifier used for Intermediary Manual Part 4. This indicator is followed by a dash and the related section number. All sections in this chapter came from the Medicare Intermediary Manual Part IV (A4).

10 - Provider Audits - General

(Rev. 9, 08-30-02)

A4-4100

Providers receiving payments under Parts A and B of title XVIII of the Social Security Act, (the Act), as amended, are subject to audit for all payments applicable to services rendered to Medicare beneficiaries. The audit ensures that proper payments were made on the basis of reasonable costs of covered services, to provide verified financial information for making a final determination of allowable costs, to discover any instances of fraud and abuse, and to develop other information CMS needs to fulfill its responsibilities. These audit requirements include guidelines for performing audits that fulfill these requirements.

10.1 - Intermediary Responsibilities

(Rev. 9, 08-30-02)

A4-4100.1

In carrying out its contractual responsibilities for assuring that proper payments are made, the intermediary shall determine, on an individual provider basis, whether audit is necessary and where it is, that its scope is appropriate under the circumstances. In developing the scope of the audit, it shall consider:

- Materiality;
- Past experience or your knowledge of the provider;
- Impact of potential audit adjustments; and
- Utilization.

It shall document the basis for each decision regarding the audit.

Regardless of the method employed to audit providers, the intermediary shall formulate and adhere to annual audit plans and priorities in making audit decisions. (See §30.) Any changes must receive RO concurrence. The intermediary shall adhere to changes to audit policies, procedures, and priorities required by CMS.

10.2 - Definitions

(Rev. 9, 08-30-02)

A4-4100.2

A - Uniform Desk Review

The Uniform Desk Review (UDR) is an analysis of the provider's cost report to determine its adequacy and completeness, accuracy and reasonableness of the data

recorded, and a summary of review results to either settle the cost report without field audit or to determine the extent to which field audit verification is required.

It consists of:

1 - Clerical review

- Determination of its completeness;
- Verification of its mathematical accuracy;
- Entry of cost report data into an automated data base where the intermediary uses an automated desk review system; and
- Preparation of the prior and current year's cost report data comparison when needed for the professional review.

2 - Professional review

- Determination of whether to perform a field audit and its scope based upon factors and steps which may include, but are not limited to:

a. Comparison of prior and current year's cost report data,

b. Follow-up on corrective actions on deficiencies noted from prior desk review and/or field audit,

c. Reasonable cost determination by comparison with published limits and established guidelines,

d. Determination of inconsistencies in the application of generally accepted accounting principles and Medicare program policies and procedures,

e. Determination of the existence of reasonable support for cost and statistical data based upon prior experience,

- Summarization of findings regarding whether to field audit and its scope; and
- Summarization of issues and findings for subsequent year desk reviews.

The UDR is a survey. It is a process to review information on the provider, without detailed verification, and is designed to identify problem areas warranting additional review and to obtain information for use in planning and accomplishing the field audit.

B - Field Audit

A field audit is the performance of prescribed procedures in the examination and verification of data maintained by the provider. It encompasses a written record of the work performed and the results. It includes:

- An examination of statistical and financial transactions, accounts, and reports including an evaluation of compliance with applicable laws and regulations.
- A review of efficiency and economy in the use of resources.
- A review to determine whether desired results are achieved.

The intermediary shall limit Medicare cost reports audits to compliance audits described above.

C - Abuse

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

D - 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.

20 - Contractor Responsibility in Suspected Fraud or Abuse Cases

(Rev. 9, 08-30-02)

A4-4101

If the intermediary or its subcontract auditor identifies a potential fraud or abuse situation, it shall notify the Office of Program Integrity, OIG, RO.

The following are examples 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 splittings, 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.

Where the intermediary identifies a questionable situation, it is generally appropriate to continue an 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 the intermediary discuss a possible fraud or abuse situation with the provider, or take any action to resolve such questionable situations prior to receiving instructions from the OIG.

The intermediary shall take no action to disallow questionable costs involving possible fraud or abuse without specific instructions from the OIG. It shall provide necessary guidance to providers in preparing their cost reports. If certain cost items are discovered during an audit or desk review, which are nonallowable, it shall make the necessary adjustments and inform the provider. It shall document any adjustments made to the cost report.

NOTE: If a suspicion of any intent to defraud the United States Government is supported by even the initial insertion of a nonallowable item on the cost report, no warning is required prior to prompt referral to the OIG for investigation and possible prosecution.

If these same nonallowable costs appear on a subsequent cost report, the intermediary shall tell the provider again why they are disallowed. It shall confirm this notification in a letter. It shall 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 for consideration of criminal and/or civil prosecution.

The intermediary shall adapt 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 could result in the referral of this situation to the U. S. Attorney for consideration of criminal and/or civil prosecution.
>
> Should you have any questions, please contact (intermediary).

If the provider continues to include these nonallowable costs after receipt of the letter, the intermediary shall refer the case to the OPI, RO.

These instructions do not apply where the allowability of a cost item is disputed, and the provider clearly indicates on the subsequent cost report that the particular item is still disputed and is included to establish the basis for an appeal.

30 - Audit Work Plan and Selection Process

(Rev. 9, 08-30-02)

A4-4104

The audit work plan and selection process is influenced by the budgetary restrictions imposed upon the intermediary and the findings from the UDR. The intermediary shall establish audit work according to the Audit Priority Matrix. (See Chapter 8, §270.) It shall adhere to it except upon advising the RO of the need for changes and obtaining its concurrence. It shall monitor progress to determine whether the desired results are being achieved.

30.1 - Audit Priority Considerations

(Rev. 9, 08-30-02)

A4-4104.1

One or more of the audit priority considerations may enter into the decision to audit, the degree to which audit coverage is to be given, and the scope of each type. Conversely, selected cost reports may require an audit even though other considerations are not satisfied. The audit priority matrix (see §270) arrays these considerations for each type or provider grouping. When the predetermined circumstances occur, the intermediary shall decide the need to audit and the extent to which audit coverage is necessary by referring to the work plan. The considerations are weighted and laid out in the audit priority matrix. They are not prioritized, nor all-inclusive. Some may not be completely defined until the formulation of the work plan.

A - Significance of Total Medicare Program Payments

Large providers, with significant Medicare reimbursement, are generally the most cost beneficial audits to perform due to the potential for major adjustments.

B - Cost Benefit

The prevailing consideration behind the criteria for selecting audits is generally cost benefit. This is not always determinable prior to audit.

C - Types of Providers

Special attention may be required for certain types of providers because of known or anticipated problems or circumstances.

D - Conditions and Occurrences at the Provider

- Change in ownership or termination;
- Significant change in personnel or organization;
- Intermediary prior experience, especially with the condition of the provider's records or reporting habits;
- Overpayment in the prior and/or current year;
- High interim rate compared to other comparable facilities;
- Cost report filed late with an unsatisfactory explanation;
- Adjustments on previous reports, where the intermediary believes that similar problems exist on the current reports;
- Frequency and types of audits performed by other auditors; and
- Fraud or abuse investigation as directed by the OIG.

E - Critical or Sensitive Reimbursement Areas

The intermediary shall give particular attention to cost reports that frequently include appealed or protested issues to assure that adjustments are properly handled. These may be of national impact or found only in certain regions, some may be major changes in reimbursement policies.

30.2 - Audit Selection

(Rev. 9, 08-30-02)

A4-4104.2

After Part I of the UDR has been completed, and considering the audit priorities, the intermediary shall:

- Settle the cost report as filed, or
- Perform Part II of the UDR to determine if field audit is necessary, and/or
- Perform a field audit.

A - Cost Report Settlement Without Audit

The intermediary may have sufficient documentation to settle the cost report with the proposed adjustments, if any, without audit. Under this circumstance, it shall verify the mathematical accuracy of the cost report if necessary. It is not necessary to mathematically verify if it was electronically transferred or if every worksheet was computer prepared by an approved system or vendor. The intermediary shall assess the reliability of hard copy computer-prepared cost reports, based upon prior experience in determining the need for mathematical verification. If it finds that a computer-prepared

cost report that CMS has determined to be acceptable is not mathematically reliable, it shall report this immediately to:

Centers for Medicare & Medicaid Services
Office of Financial Management
7500 Security Blvd.
Baltimore, MD 21244

The intermediary shall select for its review and audit from these cost reports. The frequency of selection depends upon budgeted funds available in accordance with the audit priority matrix. This selection serves as a deterrent to providers that otherwise do not fall into audit categories. In addition, it forms the basis for a self-assessment of the adequacy of the Part I professional review process and of the budgeted audit priorities.

B - Cost Reports to be Field Audited After UDR - Part I

An alternative after completing Part I of the UDR is to refer the cost report directly to field audit. The intermediary shall do this when the reviewer establishes the need for audit and identifies issues based upon the findings from Part I. Selected areas of Part II of the UDR may be performed after Part I has been completed to adequately scope the audit of individual issues. Budgetary audit priorities greatly influence this audit decision and the scoping process.

C - Cost Reports for Professional Review - Part II

Part II is necessary for cost reports where issues are identified in Part I but are not sufficiently developed at that point to allow an audit/no audit determination. The main purpose of this review is to establish whether an audit is necessary and, if so, to set its scope.

30.3 - Documentation of Selection Process

(Rev. 9, 08-30-02)

A4-4104.3

Since the process for selecting cost reports for audit relies heavily upon the reviewer's professional judgment, the reviewer shall document the basis for the decision. It shall document all predetermined identifiable characteristics or circumstances of the provider's organization, operation, or cost report set forth in the annual audit plan which serves as the basis for making decisions on desk review and/or the field audit.

A decision to defer audit must be consistent with the instructions for selecting cost reports and the budgeted audit priorities.

40 - Audit Responsibility When Provider Changes Intermediaries

(Rev. 9, 08-30-02)

A4-4105

The responsibility for auditing a provider that has changed intermediaries rests with the outgoing intermediary. This is based upon the contractual functions to be performed by intermediaries outlined in Article II, Sections A, B, and C of the Agreement.

These sections require the intermediary 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 intermediary servicing the provider to account for all transactions that have taken place while the relationship existed. Logic dictates that the outgoing intermediary is responsible for the provider's previous fiscal year. This includes an audit of the provider's records and negotiation of the final settlement.

Generally, the intermediary shall audit the first cost report filed by a provider that is new to the program, or new to the intermediary as a result of changing intermediaries. This gives the intermediary a basis from which to review and evaluate subsequent years' cost reports. The audit of a cost report from a provider that changed intermediaries is:

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

40.1 - Provider Statistical and Reimbursement Report

(Rev. 9, 08-30-02)

A4-4105.1

For the period that it serviced the provider, the outgoing intermediary shall furnish the incoming intermediary with copies of the PSRR necessary to the incoming intermediary for reimbursement purposes.

40.2 - Audit Reports

(Rev. 9, 08-30-02)

A4-4105.2

When the outgoing intermediary has performed a provider audit, it forwards a copy of the audited cost report to the incoming intermediary. This furnishes audited cost information so the incoming intermediary may evaluate the interim rate assigned. For comparison purposes when the provider completes the audit and final settlement of the cost report in the current fiscal period, the final rate can be compared to the interim rate.

50 - Desk Review

(Rev. 9, 08-30-02)

A4-4108

The intermediary's desk review activities must comply with the requirements of the Uniform Desk Review (UDR) program. (See Chapter 6, §§10ff.) The intermediary shall use its desk review program as long as it covers, at a minimum, all areas covered in CMS's UDR program.

50.1 - Functions of the Desk Review

(Rev. 9, 08-30-02)

A4-4108.1

The desk review is a survey that evaluates the adequacy and accuracy of the cost report and related information to determine the need for field audit and its scope. The desk review:

- Determines mathematical accuracy of the cost report,
- Evaluates reasonableness of entries by comparing the current period information with the immediately preceding period(s),
- Analyzes entries for reliability by referring to permanent files and prior audits.
- Analyzes information readily available to the intermediary without detailed on-site verification.

50.2 - Determining the Depth of the Desk Review

(Rev. 9, 08-30-02)

A4-4108.2

Where Part I of the UDR establishes the need for completing Part II (see §30.2C), the intermediary shall perform the variance analysis and applicable sections of the UDR. Provider conditions and circumstances determined from the Provider Cost Report Reimbursement Questionnaire (Form CMS-339) establish the areas to address within the UDR programs. For example, the provider indicates that there is a new bond issue to refinance existing debt. If this provider's cost report is selected for desk review, the intermediary shall review interest expense. As a result of the desk review, it shall develop specific review points. For example, the review point for a refinancing of previous debt may be stated as follows: "The provider has defeased a $10,000,000 bond issue using the proceeds of a new $20,000,000 issue. As a result of this transaction, the provider incurred a $350,000 loss. Review the transaction to ensure that the loss has been treated in accordance with PRM, Part I, §233." Conversely, where the same provider indicated there are no changes to its pension plan, which had been accepted in prior years, and the current pension expense is comparable to that incurred in previous years, then the intermediary shall exclude this area from desk review.

Where Part I of the UDR establishes the need for additional investigation (see §30.2B), the intermediary shall perform selected portions of Part II to further develop the findings of Part I, and scope specific areas for audit. The information obtained aids in focusing the audit on the areas that will most likely generate adjustments.

60 - Standards for Audit Under Medicare

(Rev. 9, 08-30-02)

A4-4112

In July 1988, the Comptroller General of the United States issued revised Government Auditing Standards (GAS) that are applicable to all audits performed by or for any Federal agency. These revised standards are effective for any Medicare audits performed on or after January 1, 1989. In addition, Medicare audits are subject to the Statements on Auditing Standards (SAS) issued by the American Institute of Certified Public Accountants (AICPA), unless individual standards are specifically excluded by Medicare audit policy. Therefore, the SASs applicable to financial statement audits are applicable to Medicare cost report audits.

The intermediary's audits of cost reports are governed by GAS (Chapter 3 - General Standards, Chapter 4 - Field Work Standards for Financial Audits, and Chapter 5 - Reporting Standards for Financial Audits) which determines if the Medicare cost report of the audited entity has complied with the prospective payment system (PPS), the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), and reasonable cost regulations in the Code of Federal Regulations (CFR).

60.1 - Scope of Audit

(Rev. 9, 08-30-02)

A4-4112.1

A Medicare cost report audit is an examination of the provider's financial records and activities as they relate to Medicare payment. Considering Medicare priorities, the intermediary shall determine, after completing its desk review process, whether an audit of the provider's cost report is necessary. It shall determine whether a full or a limited scope audit is in order, and if limited, the specific areas to examine. When feasible, it shall utilize the provider's financial statement and auditor's working papers to accomplish its audit workload requirements. The following definitions pertain to types of Medicare audits.

A - Full Scope Audit

A full scope audit includes an examination of financial transactions, accounts, and reports, and compliance with applicable Medicare laws, PPS and TEFRA regulations, manual instructions, and directives. It is of sufficient depth and detail to assure that program payment is based upon Medicare principles of payment. The intermediary's full scope audit should include an adjustment report that presents adjustments to the provider's as-filed costs. The intermediary should assure that the adjusted audited Medicare cost report reflects costs in conformity with the Medicare principles of payment.

A full scope audit is not required in most circumstances.

B - Limited Scope Audit

A limited scope audit is an audit of a selected part of a provider's cost report and related financial records. In addition, 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 are sufficient to meet the audit objectives established from the desk review. When an audit is being performed and additional audit procedures are required, or additional findings are discovered which may require additional audit procedures, the intermediary shall make a prompt evaluation and either approve or disapprove the additional expenditure of audit resources. Its audit report includes an adjustment report that presents adjustments to the provider's as-filed costs so that the audited Medicare cost report reflects costs in conformity with the Medicare principles of payment.

60.2 - Determining the Depth of Audit

(Rev. 9, 08-30-02)

A4-4112.2

The intermediary shall audit provider records in sufficient depth and detail to provide reasonable assurance that program payment is based on Medicare principles of payment, as appropriate. For the first year a provider participates, the intermediary shall make a comprehensive audit using the CMS Hospital Audit Program and the HHA Audit Program to assure compliance with the Medicare requirements for payment stated in the PPS and TEFRA regulations, and the reasonable cost regulations, in the Code of Federal Regulations (CFR). An initial year audit should provide a good basis for comparison of variances in subsequent periods. Consequently, subsequent audits may be more focused.

60.3 - Standards for Performing Medicare Audits

(Rev. 9, 08-30-02)

A4-4112.3

In performing a Medicare audit, the intermediary shall comply with the General, Field Work, and Reporting standards of the Government Auditing Standards (GAS). Also, the American Institute of Certified Public Accountants (AICPA) Statements on auditing standards have been adopted and incorporated as GAS requirements.

Chapter 3 of the GAS, or "yellow book," entitled General Standards, outlines the general standards for conducting government audits. These standards apply to all audit organizations, both government and nongovernment (e.g., public accounting firms), which conduct government audits, unless specifically excluded. The general standards applicable to Medicare audits are:

- Qualifications;
- Independence;
- Due Professional Care; and
- Quality Control.

60.3.1 - Qualifications

(Rev. 9, 08-30-02)

A4-4112.3.A

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."

The intermediary shall ensure that the Medicare audit is conducted by staff who collectively have the knowledge and skills necessary for the audit. These qualifications apply to the knowledge and skills of the intermediary's organization as a whole, and not necessarily to every individual auditor.

1 - Continuing Education and Training (CET)

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

The following represents its continuing education responsibilities as an audit organization, and also reflects additional guidance from CMS to help the intermediary meet the requirements imposed by GAS.

2 - 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. Auditors conducting audits in accordance with GAS on January 1, 1999, must complete the CET requirements as follows:

- The first 80 hours must be completed by December 31, 2000. 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, 1999, to December 31, 2000) 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 intermediary 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 intermediary'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 intermediary 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.

3 - 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 intermediary 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 intermediary 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 intermediary. The intermediary 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 intermediary'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 intermediary employees, 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.

The intermediary shall review all position descriptions to ensure that they accurately reflect the employees' duties and responsibilities. If it has concerns or questions on certain position descriptions, it shall submit its questions to its 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.

4 - FI Responsibility

The intermediary shall establish and implement a program to ensure that the auditors meet the CET requirements. It must:

- Prepare a general plan for training. It shall 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 its employees receiving CET credit for FI-sponsored courses. It shall maintain records for a five-year period from the

completion of the two-year period. It shall maintain a record for each employee which reflects:

f. Record of participation;

g. Course agenda;

h. Course date(s);

i. Location at which the course was given;

j. Name(s) of instructor(s) and related training, education, and experience;

k. Number of CET credit hours; and

l. Copy of course material presented.

- Retain course information for employees receiving CET credit for courses outside the FI. It shall maintain records for a five-year period from the completion of the two-year period. It shall obtain a letter of completion or certificate, and retain a record for each employee which reflects:

m. Name of course;

n. Course date(s);

o. Location at which the course was given;

p. Course sponsor; and

q. 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.

5 - 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 intermediary 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.

- FI-Sponsored Training - The intermediary 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 who are required to obtain continuing professional education credits for CPA licensure. In the development of in-house training, the intermediary 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 intermediary 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, but 50 or more minutes, 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 intermediary 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 audio cassettes, tapes, videotapes, and computers. (See the AICPA's standards for more detailed requirements.)

6 - 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.

For further discussion on qualifications, see "Government Auditing Standards," pages 3-3 and 3-4.

60.3.2 - Independence

(Rev. 9, 08-30-02)

A4-4112.3.B

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."

The intermediary shall maintain independence so that opinions, conclusions, judgments, and recommendations are impartial and viewed as impartial by knowledgeable third parties.

It shall 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 intermediary 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 intermediary 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 the intermediary is 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 based on Medicare payment formulas or payment methods.

The intermediary shall establish policies and procedures to provide reasonable assurance that all Medicare audit and payment professional staff maintain their independence so as

not to impair, or appear to impair, the intermediary's independence in carrying out its Medicare audit responsibilities.

For further discussion of independence, see "Government Auditing Standards," pages 3-4 through 3-10.

60.3.3 - Due Professional Care

(Rev. 9, 08-30-02)

A4-4112.3.C

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 intermediary 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. The intermediary shall follow the same judgment in conducting the tests and procedures and in evaluating and reporting on the audit results.

1 - Materiality and Significance

In planning the audit, selecting the methodology, and designing audit tests and procedures, the intermediary shall consider materiality and significance. It shall communicate to its audit staff its quantifiable parameters for materiality and significance.

2 - Relying on the Work of Others

In conducting an audit, auditors may rely on the work of others, to the extent feasible, once they satisfy themselves with the quality of the others' work by appropriate tests or by other acceptable methods.

In planning field audit of a cost report, the intermediary shall consider any other audits of the provider that may have an impact upon the cost report. Generally, these audits include those performed by the provider's independent auditors, but may also include those performed by internal auditors or audit organizations established by Federal and State governments for programs other than Medicare.

Once it establishes the reliability of the other audit work, the intermediary shall consider the scope of the other audit and its relationship to the scope and objective of the examination during the Medicare field audit.

For further discussion on relying on the work of others, see §60.4.1(1)c.

3 - Obtaining Management Letter Prepared by a Provider's CPA Firm

The revised GAS requires that all audit organizations obtain an understanding of an entity's internal control structure. However, §60.4.3 outlines CMS's policy on when an internal control review is not required. If the intermediary determines that it is necessary to gain an understanding of a provider's internal control structure, it shall obtain the provider's CPA Management Letter. In lieu of the management letter, it shall ask the provider to have its CPA firm provide the intermediary with a written statement that reports on all matters (strengths, weaknesses, etc.) relating to the overall reliability of the provider's internal control structure. The intermediary shall ensure that the information is in sufficient detail to help it obtain an understanding of the provider's internal control structure. It shall keep management letters obtained from a provider in a secure place. It shall disclose the contents only to those directly involved with the audit. The CPA Management Letter may be obtained for reasons other than gaining an understanding of a provider's internal control structure, based on the intermediary's professional judgment.

The authority for obtaining the management letter or the alternative CPA letter is §1815(a) of the Act that is contained in 42 CFR §413.20 (d). If a provider refuses to supply the requested information, the intermediary shall follow suspension procedures in 42 CFR §413.20 (e) which require it to send prior notice of suspension of payments in accordance with 42 CFR §405.371(a).

The intermediary shall give providers an opportunity to protest the suspension.

4 - 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. The intermediary shall determine whether prompt and appropriate actions have been taken on findings and recommendations by provider officials or other appropriate organizations.

5 - 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.

For further discussion of due professional care, "Government Auditing Standards," pages 3-10 through 3-17.

60.3.4 - Quality Control

(Rev. 9, 08-30-02)

A4-4112.3.D

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."

The intermediary shall establish an internal quality control program and provide reasonable assurance that its Medicare audit department:

- Has established, and is following, adequate audit policies and procedures; and
- Has adopted, and is following, applicable auditing standards.

1 - External Quality Control Review (Review of the Internal Quality Control System)

OIG will perform an external review of the intermediary's internal quality control system. CMS will also review the intermediary's internal quality review program as part of UNICEP. Any tests of its internal quality control system must evaluate:

- The existence of such a system;
- Compliance with the system; and
- The effectiveness of the system.

2 - Establishment of an Internal Quality Control System

The intermediary shall establish internal quality control policies and procedures for its Medicare audit department, i.e., all Medicare audit and payment related activities. It shall 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 FI than a smaller FI, and more extensive in a multi-office FI than in a single-office FI. Therefore, in developing such a system, the intermediary shall consider the following factors:

- The size of its Medicare audit department;
- The degree of operating autonomy allowed to its personnel and audit offices;
- The nature of its work;
- Its organizational structure; and
- The cost effectiveness of an internal quality control system.

3 - Elements of Internal Quality Control

In addition to the other elements of GAS and Generally Accepted Auditing Standards (GAAS), the intermediary shall consider each of the elements of internal quality control listed below, to the extent applicable to its operating environment, in establishing its 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 who 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.

4 - Application of the Elements of Internal Quality Control to the Medicare Environment

a. Independence

The intermediary shall establish policies and procedures to provide reasonable assurance that all Medicare audit and payment professional staff maintain their independence so as not to impair, or appear to impair, the intermediary's independence in carrying out its Medicare audit responsibilities. It 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. It must obtain a separate representation for each audit.

- Obtain from its personnel periodic, written representations of their independence on an annual basis, stating that:

r. They are familiar with the intermediary's independence policies and procedures.

s. 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.

t. Personal, professional, or family relationships with providers and related entities do not exist and did not exist during the period. The intermediary shall list any relationships with an explanation.

u. There were no transactions that might impair the extent of inquiry or disclosure, or affect audit findings in any way. The intermediary shall list any transactions with an explanation, including the names of the parties to the transaction.

b. Consultation

The intermediary shall 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. It must:

- Maintain technical manuals (e.g., GAS, SAS) and Medicare manuals.
- Issue memorandums 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.

c. Assignment of Personnel to Audits

The intermediary shall establish policies and procedures to provide reasonable assurance that persons who have the degree of technical training and competence required for the circumstances will perform work.

The intermediary shall 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.

d. Supervision

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

It shall assure that the policies and procedures for planning, performance, and supervision of audits meet the GAS standards of quality. It 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:
    - a. Guidelines for the form and content of working papers;
    - b. Procedures for resolving differences of professional judgment among members of an audit team; and
    - c. Standard forms, checklists, and questionnaires appropriate to assist in the performance of audits.
- Provide procedures for reviewing audit working papers and reports.

(See §60.4.2 for further discussion on supervision.)

e. Hiring

The intermediary shall 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.

f. Professional Development

The intermediary shall 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 its Medicare audit department.

While GAS requires it 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. The intermediary 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.

g. Advancement

The intermediary shall 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. It 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. It shall maintain personnel files containing documentation relating to the evaluation process.

h. 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, the intermediary shall make a full and immediate disclosure to its 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 §20.)

i. Inspection

The intermediary shall 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. It shall monitor the effectiveness of inspection policies and procedures. It shall develop the procedures for inspection and ensure that inspections are performed by individuals acting on behalf of its management. It must:

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

For further discussion of quality control, see "Government Auditing Standards," pages 3-17 and 3-18.

60.4 - Field Work Standards

(Rev. 9, 08-30-02)

A4-4112.4

Chapter Four of GAS outlines the field audit standards for conducting government financial related audits. These standards are supplemental to the AICPA field audit standards that apply to all financial related audits. The GAS and AICPA standards apply to all audit organizations (e.g., intermediaries, public accounting and consulting firms) conducting government financial audits, unless specifically excluded.

This section describes the GAS and AICPA auditing standards applicable to the Medicare financial audit.

The field work standards applicable to Medicare audits are:

- Planning and Supervision;
- Evidence; and
- Internal Control.

60.4.1 - Planning and Supervision

(Rev. 9, 08-30-02)

A4-4112.4.A

The first GAS field work supplemental planning standard for government financial related audits states:

> "Planning should include consideration of the audit requirements of all levels of government."

The Medicare audit is a special-purpose audit, used to determine the amount of Medicare payment due to the provider, with Medicare-specific requirements being the primary source of concern. Therefore, the Medicare auditor does not have to consider the requirements of any other government agency.

The second GAS field work supplemental planning standard for government financial related audits states:

> "A test should be made of compliance with applicable laws and regulations."

The purpose of the Medicare audit is to ensure that the provider has recorded financial-related and other data on the Medicare cost report in accordance with Medicare laws,

regulations, and instructions. The Medicare audit program is designed to test the provider's compliance with such laws, regulations, and instructions.

If, in determining compliance with laws and regulations, the intermediary identifies a situation in which there is potential fraud or abuse, it shall notify its RO and the OIG for further instructions. (See §20.)

For further discussion of the GAS field work standards for planning, see "Government Auditing Standards," pages 4-1 through 4-5.

The AICPA field work standard for planning and supervision states:

> "The work is to be adequately planned, and assistants, if any, are to be adequately supervised."

1. Planning

Adequate planning of audit work supports the audit objectives and anticipated scope of audit. GAS field work standards state that "In conducting audits in accordance with the standards in this statement, the auditors should choose and conduct audit tests and procedures that, in their professional judgment, are appropriate in the circumstances to achieve the audit objectives. Such tests and procedures are designed to obtain sufficient, competent, and relevant evidence that will provide a reasonable basis for their opinions, judgments, and conclusions regarding the audit objectives."

Planning the audit involves the process of assessing information gathered during the desk review before the start of the audit. The intermediary shall use this information to obtain an understanding of the provider's organizational structure, operating characteristics, and key accounting policies. This familiarizes it with the unique characteristics of the provider and provides the basis to establish the audit objective and audit scope.

To assist it in the audit planning process, it shall have available the following information:

- 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.

It shall use this information as necessary in conjunction with the audit tools described below in planning its Medicare audit.

a. Desk Review Program

The intermediary shall use the information above, in conjunction with its desk review program, to obtain a thorough understanding of the provider's as-filed cost report and to identify significant differences or unusual fluctuations in data between the current and prior cost reporting periods which may require more detailed field audit investigation. A properly completed desk review is essential for planning the audit and establishing the audit objective.

The completed desk review supports the intermediary's:

- Statement of audit objectives;
- Method of communicating the audit objectives to intermediary staff; and
- Definition of the audit expectations.

Once the desk review has been completed, problems have been identified, and the decision has been made to field audit the provider's cost report, the intermediary shall begin the field audit planning process.

b. Audit Programs

The intermediary shall prepare a written audit program for each audit. This is essential to conduct the audit efficiently and effectively. The audit program provides the audit procedures that must be followed by the auditors to achieve the audit objectives. The intermediary shall consider the following in preparing the written audit program:

- The desk review results;
- The CMS Hospital Audit Program, or the HHA Audit Program, as applicable; and
- CMS mandated review areas, such as TEFRA and PPS audit guidelines. (See §100.)

c. Reliance on Work Done by Other Auditors

In planning the field audit of a cost report, the intermediary shall consider other audits of the provider that may have an effect upon the cost report. Generally, these audits include those performed by the provider's independent auditors on the provider's financial statements, but may also include those performed by internal auditors or audit organizations established by the Federal and State governments for programs other than Medicare.

Other audits may serve as a basis on which the intermediary can establish the scope of its examination. In determining the extent of its examination, it shall consider whether the other audits generated favorable or adverse results. Favorable audit results (e.g., the audit opinion is unqualified) establish the basis for limiting the intermediary's examination to areas of its concern. Conversely, adverse audit results (e.g., the audit opinion is qualified) may establish the basis for adjusting the cost report or expanding its examination. By relying on other auditors' work, the intermediary can avoid duplication of audit work and save itself of time for other audit efforts.

The intermediary shall determine the extent, if any, to which it may rely on other audit work. In making this determination, it shall consider the general nature of the other audit's objective, such as the objective of financial statement audits made by independent auditors.

If the other audit work is required to be performed under standards required for Medicare purposes, quality is assumed unless there is something so obvious to the intermediary that it raises doubt as to the reliability of the audit as a whole.

Once it establishes the reliability of the other audit work, the intermediary shall consider the scope of the other audit and its relationship to the scope and objective of the examination during the Medicare field audit. It may be appropriate to review the scope of the other audit and the audit program, and to review the working papers to establish the other audit work's usefulness to the Medicare audit.

d. Payment to Provider's Accountant for Assistance

In preparation for, or during a provider audit, the intermediary shall examine the working papers or ask certain questions of the provider's outside accountant or auditor in order to simplify its audit.

Prior to obtaining requested audit information from the provider's accountant, the intermediary shall determine the accountant's billing intention. Where the accountant intends to bill it, the intermediary shall obtain an estimate of the bill. Estimated charges are acceptable to a maximum of $1,000. Where the estimate exceeds that amount, the intermediary shall notify its RO of the amount, along with its recommendation and rationale for paying the larger sum. The RO evaluates the request and notifies the intermediary of its decision.

2. Supervision

Supervisory review is the assessment of each auditor's work. The intermediary shall ensure that the audit work is properly conducted, the audit objectives are accomplished, and staff is provided with effective on-the-job training. To improve the staff performance and the quality of audits, the intermediary shall consider the supervisory review an integral part of staff development.

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 workplan. Proper supervision must be a constant activity starting with the planning process through completion of the audit and preparation of the audit report. Supervision is required so that each member of the audit team understands the objective of each audit procedure, how to perform and document the completion of the audit procedure in the working papers, and how to evaluate the audit evidence.

b. Supervisory Review of Working Papers

AICPA and GAS field work standards require that a record of the auditors' work be retained in the form of working papers.

Audit working papers and associated files are the principal evidence of the intermediary's audit activities to support conclusions stated in the audit report. The intermediary shall document supervisory review of the work conducted in the working papers. In performing its working paper reviews, it shall use the material in §§60.4.2(3)i, j and k.

60.4.2 - Evidence

(Rev. 9, 08-30-02)

A4-4112.4.B

The AICPA field work standard on evidence for a financial related audit states that:

> "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."

The GAS field work 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."

The intermediary shall ensure that evidence obtained during the course of the audit is sufficient to enable the auditor to support conclusions, adjustments, and recommendations. It shall 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.

1. Sources and Categories of Evidence

The intermediary shall 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.

The intermediary shall 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, leases, minutes of meetings, written or oral testimony of provider employees.

Categories of evidence include:

a. 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.

b. 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, and checks.

c. 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, statistical bases, and allocations.

d. 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. The intermediary shall evaluate all such information and corroborate with additional evidence.

In evaluating the effectiveness and usefulness of evidence, the intermediary shall 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. It shall obtain additional evidence in order to reach a valid conclusion and achieve the audit objective.

If there is sufficient and reliable evidence to make an adjustment to the cost report, the intermediary shall make that adjustment and document it in the working papers.

e. Sampling

Sampling is the application of an audit procedure to less than 100 percent of the items within an account balance or class of transactions to evaluate some characteristic of the balance or class. On the basis of facts known to the auditor, the intermediary shall decide if all transactions or balances that make up a particular account are reviewed in order to

obtain sufficient evidence. In most cases, however, the 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 or class of transactions.

1. Planning Samples

Planning involves a strategy for conducting the audit. When planning a particular sample, the intermediary shall consider:

- The relationship of the sample to the audit objective;
- Preliminary estimates of materiality levels;
- The allowable risk of incorrect acceptance; and
- Characteristics of the population, i.e., the items comprising the universe.

2. Selecting a Sampling Approach

Because either nonstatistical or statistical sampling can provide sufficient evidence, the intermediary shall 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, the intermediary quantifies sampling risk in limiting it to an acceptable level. However, statistical sampling involves additional costs of designing individual samples to meet the statistical requirements and selecting items to be examined.

3. Sampling Risk

In performing substantive tests of details, the intermediary shall 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.

2. Documentation Standards

Documentation that the evidence obtained, procedures applied, and tests performed provide sufficient competent 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) considered necessary in the circumstances, the intermediary shall retain or refer to such evidence and its relationship to the basis for the opinions, judgments, conclusions, or examinations. Where materiality is a factor, it shall define "materiality" within the scope and objective of the review. These standards apply to both the desk review and the field audit.

3 - Working Papers

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.

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) reached in the engagement. 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.

The intermediary shall 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.

a. 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.

b. Format of Working Papers

The intermediary’s working paper requirements should ensure that the working papers follow certain standards.

As a whole, a good set of working papers:

- Is cross-referenced to a written audit program;
- Contains the objectives, scope, methodology, and results of audit;
- Is complete and accurate in order to provide proper support for findings, judgments, conclusions, and to document the nature and scope of the work conducted;
- Contains sufficient information so that supplementary oral explanations are not required;
- Is legible, with adequate indexing and cross-referencing, and includes summaries and lead schedules, as appropriate;
- Restricts information to matters that are materially important and relevant to the objectives of the audit;
- Is dated and signed by the preparer; and
- Contains evidence of supervisory review of the work.

Each individual working paper should start with a 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; and
- Working paper number or reference.

c. Purpose

A brief description of the work to be done on the working paper and the objective to be achieved (e.g., a test of laundry statistics to validate the data reported on Worksheet B-1, a comparison of the intermediary's PS&R with the as-filed settlement data to validate the provider's claimed Medicare statistics).

d. 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 comes from.

e. 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.

f. Explanation of Tick Marks

The intermediary shall use tick marks to explain and cross-reference the work performed.

g. Conclusion

When a working paper is complete, the intermediary shall state conclusions covering the results of the audit activity.

EXAMPLE:

No exceptions were noted in the test; therefore, the as-filed statistic for the allocation of laundry costs is accepted.

EXAMPLE:

Exceptions were noted in the as-filed statistic for the allocation of laundry costs. An adjustment is proposed to correct the as-filed statistic.

h. 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.

The intermediary shall adopt reasonable procedures for safe custody of working papers and retain them for a sufficient period of time to meet the needs of its operation and to satisfy legal requirements of record retention.

i. 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 the intermediary performed to support its decision on the accuracy of the final settled Medicare cost report.

AICPA field work standards require that "the work is to be adequately planned and assistants are to be properly supervised." An element of supervision is a thorough supervisory review of the audit working papers. 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.

The intermediary shall 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 SASs; and
- Provider accounting procedures.

j. 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.

k. 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 workplan 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 workplan is completed;

- Ensure that the working papers meet the mechanical and analytical requirements for quality working papers;
- Ensure that Medicare payment policies are properly interpreted;
- Ensure that unnecessary papers are deleted from the working paper file;
- Ensure that all proposed 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;
- Prepare review notes;
- Make a final check of the working papers after the review notes are cleared; and
- Discuss the overall evaluation with the auditors to provide training and staff development.

For further discussion of evidence, see "Government Auditing Standards," pages 4-6.

60.4.3 - Internal Control

(Rev. 9, 08-30-02)

A4-4112.4.C

The AICPA and GAS field work standard for internal control states:

> "Obtain a sufficient understanding of the internal control structure to plan the audit and to determine the nature, timing, and extent of tests to be performed."

The purpose of understanding the internal control structure is to:

- Identify types of potential misstatements in the financial data under audit;
- Consider factors that affect the risk of material misstatements of that data; and
- Design substantive testing.

This requirement is not applicable to no-audits, reopenings, or audits of specifically selected areas, such as intern/resident costs or wage index reviews.

1. Medicare Internal Control Audit Policy

The intermediary shall perform provider audits to give CMS reasonable assurance that the provider's filed Medicare cost report is accurate and reflects the current Medicare principles of payment. The Medicare cost report consists of financial-related data entered

on prescribed forms and may be useful for internal planning purposes. It is not designed to give an overall view of the provider's operations as financial statements do. The Medicare cost report determines the "bottom line" Medicare payment the provider receives. The Medicare cost report is always desk reviewed and about one-third are audited to determine the appropriate amount of payment due for the cost reporting period, and also to determine any overpayment made or underpayment due.

Through the years, the Medicare audit has become very limited in scope. Audit history and intermediary experience with providers have proven to be the best tools for scoping the audit. Specific areas are targeted based on prior audit adjustments, and CMS designated audit priorities. Also, CMS is stressing through limited scoping the most prudent use of limited audit resources. Audits focus on those items and issues directly affecting Medicare payment such as new or revised legislation and regulations. Also, intermediaries are instructed to concentrate on large variances in selected areas using CMS established tolerances.

Specific rules govern what is and what is not allowable under Medicare law, regulations and instructions. Costs included on the cost report must be incurred and reported in accordance with Medicare principles in order to be determined allowable. Medicare does not regard all expenses as allowable costs, and many costs that are normally recognized under financial reporting rules are either not recognized at all, or treated differently under Medicare rules.

The intermediary shall ensure that all costs and statistics reflected on the cost report are supported by adequate documentation. It shall adjust any amounts not adequately documented. Adjustments are used to correct submitted reports and determine Medicare liability. Internal controls do not govern acceptability of a claimed cost under Medicare rules. The Medicare auditor performs substantive tests of the costs reported in the cost centers (departments) selected for review. The auditor determines if claimed costs are allowable through examination of the costs in selected areas.

After a limited scope audit is completed, the Medicare auditor issues a report to the provider outlining the specific adjustments made to the Medicare cost report, and providing a determination of the final payment amount to which the provider is entitled. The auditor does not comment on a provider's financial condition. This is unlike the provider's financial audit where an opinion is given on the fair presentation of the financial statements, taken as a whole.

A review of and reporting on a provider's system of internal control is generally not warranted, nor cost effective in the Medicare audit environment.

The auditor shall review the provider's internal control structure to gain an understanding of, and assess the adequacy of the internal control structure, when in its professional judgment it would significantly affect the scoping of the audit. In most instances, the review and assessment of a provider's internal control structure will not have a significant effect on the scope of a Medicare audit, and is not an effective Medicare audit procedure.

If internal controls are not reviewed, the preparation of a separate report on internal control is not required. Instead, in the working papers and the audit report to the provider, the auditor shall indicate the position being taken regarding the review of internal controls and cite the applicable section of the GAS for not performing an internal control review.

2. Limiting the Consideration of Internal Control

"Government Auditing Standards," page 5-7, states that "The auditor may limit the consideration of internal control structure for a number of reasons". These include:

- An adequate internal control structure does not exist for reliance thereon because of the small size of the entity;
- The auditor may conclude that it would be inefficient to evaluate the effectiveness of internal control structure policies and procedures and that the audit can be conducted more efficiently by expanding substantive tests, thus placing very little reliance on internal control structure;
- The existing internal control structure may contain so many weaknesses that the auditor has no choice but to rely on substantive testing, thus virtually ignoring the internal control structure; and
- The objectives of a financial related audit did not require an understanding or assessment of the internal control structure."

If any of these circumstances exist, the auditor shall document them in the working papers and include them in the audit report or the internal control report, if a separate document is issued. (See §60.5.3 on Reporting.)

3. Obtaining the Understanding of the Internal Control Structure

If the auditor determines that it is necessary to review internal controls, the internal control questionnaire (see Exhibit I) is designed to allow it to obtain an understanding of the provider's internal control structure as it applies to Medicare audits. Also, not all of the internal control structure of a provider is relevant to a Medicare audit. Medicare auditors are concerned with the allowability, reasonableness, classification, and accumulation of cost report data, which 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 limited audit in accordance with CMS's 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.

4. Assessing Control Risk

Assessing control risk is the process of evaluating the effectiveness of an entity's internal control structure policies and procedures in preventing or detecting material misstatements in Medicare cost report assertions. If a review of a provider's internal control structure is performed, the Medicare auditor is responsible for assessing the control risk for Medicare cost report assertions such as:

- Specific costs incurred;
- Charges imposed;
- Revenues received; and
- Statistical data.

Based on the assessment the auditor can determine the nature, timing, and extent of tests.

In situations where the internal control structure has many weaknesses or the Medicare auditor believes that performing significant tests of controls is not efficient, the auditor may conclude that control risk is significant and rely exclusively on substantive tests of the data. In such situations, no tests of controls need to be performed.

In some cases, the Medicare auditor decides that it is efficient to reduce the extent of the substantive tests of specific data by assessing control risk. The Medicare auditor obtains evidence of the operating effectiveness of internal control policies and procedures that are likely to prevent or detect material misstatements in the specific data. The auditor obtains evidence of operating effectiveness by tests of controls. Tests of controls directed toward the operating effectiveness of an internal control structure policy or procedure are concerned with the following:

- How the policy or procedure was applied;
- The consistency with which it was applied during the audit period; and
- By whom it was applied.

These tests ordinarily include procedures such as:

- Inquiries of appropriate personnel;
- Inspection of documents and reports indicating the performance of the policy or procedure;
- Observation of the application; and
- Reperformance of the application of the policy or procedure by the auditor.

The auditor shall refer to §§3135 and 4700 of the AICPA Audit and Accounting Manual for additional guidance on assessing control risk.

5. Audited and Unaudited Providers

The intermediary shall perform Medicare audits on providers that have or have not had their financial statements audited.

a. Providers That Have Had Their Financial Statements Audited

Financial statement auditors consider the provider's internal control structure policies and procedures that pertain to the organization's ability to record, process, summarize, and report financial data consistent with the assertions contained in the financial statements. While a financial statement auditor is required to obtain an understanding of the internal control structure sufficient to plan the audit of the financial statements, the auditor is not required to test the operating effectiveness of specific policies and procedures unless the test is necessary to support the auditor's assessment of control risk. Also, since the objective of a financial statement audit is not the same as that of a Medicare audit, the financial statement auditor does not consider all of the internal control policies and procedures that may be relevant to a Medicare audit.

Financial statement auditors are required by SAS No. 60 to communicate reportable conditions to appropriate levels of management within the provider's organization. A reportable condition is a matter that comes to an auditor's attention that, in the auditor's judgment, represents a significant deficiency in the design or operation of the internal control structure that could adversely affect the organization's ability to record, process, summarize, and report financial data consistent with the assertions of management in the financial statements. To supplement their understanding of internal control, the Medicare auditor should obtain from the provider:

- A copy of the written communication of reportable conditions issued to the provider by the financial statement auditor; and
- A description of any reportable conditions communicated orally to the provider, or a representation from the provider that no such matters were communicated orally.

Such reportable conditions may, or may not, be relevant to the Medicare auditor.

b. Providers That Have Not Had Their Financial Statements Audited

For unaudited providers, which are typically smaller providers, where an adequate internal control structure does not exist, or contains many weaknesses, the auditor must perform substantive testing in lieu of placing reliance on the provider's internal control structure.

Two characteristics distinguish small providers from other providers:

- Ownership or operational control is concentrated in one or a few individuals; and
- The accounting system features limited segregation of duties and functions.

From an auditing perspective, these characteristics, rather than a specific dollar amount of net assets or gross revenues, determine whether an entity is a "small business."

For further discussion on internal control, see "Government Auditing Standards," pages 4-7 through 4-8.

60.5 - Reporting Standards

(Rev. 9, 08-30-02)

A4-4112.5

Chapter Five of "Government Auditing Standards," entitled, "Reporting Standards for Financial Audits," outlines the reporting standards for conducting government financial related audits.

The GAS supplemental standards for reporting incorporates the AICPA standards for reporting for financial and financial related audits. GAS does not restate the AICPA reporting standards, but rather prescribes supplemental standards needed to satisfy the unique needs of government financial-related audits.

The intermediary shall issue reports for no audits as well as for audits. However, GAS supplemental reporting standards specifically apply to those situations in which there has been an audit of the Medicare cost report.

The GAS supplemental reporting standards for financial related audits are:

- Statement on Auditing Standards;
- Report on Compliance;
- Report on Internal Controls;
- Reporting on Financial Related Audits;
- Privileged and Confidential Information; and
- Report Distribution.

60.5.1 - Statement on Auditing Standards

(Rev. 9, 08-30-02)

A4-4112.5.A

The first supplemental reporting standard for government financial-related audits is:

> "A statement should be included in the auditor's report that the audit was made in accordance with generally accepted government auditing standards."

The auditor shall establish procedures to assure that all audit reports comply with GAS requirements. It shall ensure that the audit report contains a statement that it has audited

the provider's Medicare cost report, and the audit was conducted in accordance with GAS.

For further discussion on the statement on auditing standards, see "Government Auditing Standards," pages 5-1 through 5-2.

60.5.2 - Report on Compliance

(Rev. 9, 08-30-02)

A4-4112.5.B

The second supplemental standard for government financial-related audits is:

> "The auditors should prepare a written report on their tests of compliance with applicable laws and regulations. This report, which may be included in either the report on the financial audit or a separate report, should contain a statement of positive assurance on those items which were, tested, for compliance and negative assurance on those items not tested. It should include all material instances of noncompliance, and all instances or indications of illegal acts which could result in criminal prosecution."

The auditor shall incorporate in its report statements of positive and negative assurances on compliance with Medicare laws, regulations and instructions.

1. Reporting of Indications of Illegal Acts

Illegal acts would consist of fraud or abuse against the Medicare program. The intermediary shall 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. OIG will notify the intermediary in writing of the content of the report to be used. The intermediary shall issue a report in situations where it has made annually recurring adjustments, notified the provider, and referred the situation to OIG. (See §10.)

2. Reporting on Compliance for Providers

If the report relates to a provider's Medicare cost report, the intermediary shall incorporate a statement that GAS standards require it 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.

3. Reporting on Compliance for Home Offices and Limited Purpose Insurance Company

If the report relates to a home office cost statement or a limited purpose insurance company (LPIC) cost statement, the intermediary shall incorporate a statement that GAS standards require it to plan and perform the audit to obtain reasonable assurance about whether the Medicare home office cost statement or LPIC cost statement is prepared in accordance with Medicare laws, regulations, and instructions.

4. Cost Report Audit Adjustment Report

This is a complete listing, with Medicare cost report references, of all adjustments made to the Medicare cost report. It lists and describes items of material noncompliance referred to in the audit report. The intermediary shall describe the adjustments in sufficient detail to explain the provider's noncompliance.

For further discussion on the report on compliance, see "Government Auditing Standards," pages 5-2 through 5-6.

60.5.3 - Report on Internal Controls

(Rev. 9, 08-30-02)

A4-4112.5.C

The third supplemental reporting standard for government financial-related audits is:

> "The auditors should prepare a written report on their understanding of the entity's internal control structure and the assessment of control risk made as part of a financial statement audit, or a financial related audit. This report may be included in either the auditor's report on the financial audit or a separate report. The auditor's report should include at a minimum:
>
> - The scope of the auditor's work in obtaining an understanding of the internal control structure and in assessing control risk;
>
> - The entity's significant internal controls or control structure including the controls established to ensure compliance with laws and regulations that have a material impact on the financial statements and results of the financial related audit; and
>
> - The reportable conditions, including the identification of material weaknesses, identified as a result of the auditor's work in understanding and assessing the control risk."

At a minimum, the intermediary shall include in its audit report or separate internal control report the scope of the auditor's work in obtaining an understanding of the internal control structure. Internal control structure categories include:

- The internal control environment;

- The accounting system; and

- The internal control procedures applicable to the preparation of the Medicare cost report.

The auditor may satisfy this requirement by stating that they assessed control risk and obtained an understanding of relevant internal control structure policies and procedures and whether they have been placed in operation.

During the course of the audit, the auditor may become aware of matters relating to the internal control structure that must be reported to the provider. If so, the auditor shall

develop a listing of reportable conditions, including the identification of material weaknesses discovered during their review of internal controls.

Reportable conditions are significant deficiencies in the design or operation of the internal control structure that could adversely affect the provider's ability to record, process, summarize, and report financial data consistent with the assertions of management in the cost report.

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 level the 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.

If no material weaknesses or reportable conditions were found, the auditor shall make the statement "No material weaknesses were found" in the audit report. The auditor shall not state "No reportable conditions were found," in the audit report or internal control report.

60.5.4 - Reporting When Internal Controls Are Not Reviewed

(Rev. 9, 08-30-02)

A4-4112.5.D

If internal controls are not reviewed, the auditor shall not prepare a separate report on internal control. Instead, in the audit report to the provider, the auditor shall indicate the position being taken regarding the review of internal controls. Also, the auditor shall cite the applicable section of the GAS relied on for not performing an internal control review.

GAS states that the auditor may limit the consideration of internal control structure in the following circumstances:

- An adequate internal control structure does not exist for reliance thereon because of the small size of the entity;
- The auditor may conclude that it would be inefficient to evaluate the effectiveness of internal control structure policies and procedures and that the audit can be conducted more efficiently by expanding substantive audit tests, thus placing very little reliance on the internal control structure;
- The existing internal control structure may contain so many weaknesses that the auditor has no choice but to rely on substantive testing, thus virtually ignoring the internal control structure; and
- The objectives of a financial-related audit did not require an understanding of the internal control structure.

For further discussion on the internal control report, see "Government Auditing Standards," pages 5-6 through 5-10.

60.5.5 - The Fourth Supplemental Reporting Standard

(Rev. 9, 08-30-02)

A4-4112.5.E

> "Prepare written audit reports giving the results of each financial-related audit."

The results of the Medicare audit are contained in the Notice of Program Reimbursement (NPR) issued with the audited Medicare cost report and the audit report, as supported by the audit adjustment report. The NPR states the Medicare payment as claimed by the provider on the as-filed cost report and the Medicare payment determined by the intermediary on the audited cost report. The audit report must reference the NPR and the audit adjustment report.

For further discussion on reporting on financial related audits, see "Government Auditing Standards," pages 5-10.

60.5.6 - The Fifth Supplemental Reporting Standard

(Rev. 9, 08-30-02)

A4-4112.5.F

> "If certain information is prohibited from general disclosure, the report should state the nature of the information omitted and the requirement that makes the omission necessary."

For further discussion on privileged and confidential information, see "Government Auditing Standards," pages 5-10 through 5-11.

60.5.7 - The Sixth Supplemental Reporting Standard

(Rev. 9, 08-30-02)

A4-4112.5.G

> "Submit written audit reports by the audit organization to the appropriate officials of the organization audited and to the appropriate officials of the organizations requiring or arranging for the audits, including external funding organizations, unless legal restrictions, ethical considerations, or other arrangements prevent it. Send copies of the reports to other officials who have legal oversight authority or who may be responsible for taking action and to others authorized to receive such reports. Unless restricted by law or regulation, make copies available for public inspection."

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

For further discussion on report distribution, see "Government Auditing Standards," pages 5-11 through 5-12.

60.5.8 - Medicare Cost Report Audit Report

(Rev. 9, 08-30-02)

A4-4112.5.H

1 - Content and Structure of the Medicare Cost Report Audit Report

The intermediary shall complete the report on its letterhead paper specifying the name of the provider or provider complex for the audit of the Medicare cost report. The report will include the provider and subprovider numbers for all components reported on the Medicare cost report for the provider complex. The intermediary shall include a separate notice of program reimbursement (NPR) specifying each provider or subprovider component name, number, and cost reporting period for each provider or subprovider component covered under the audit of the Medicare cost report.

For its Medicare audit report, the intermediary shall:

- Establish procedures to assure that all audit reports comply with GAS requirements;
- 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 its consideration of the provider's internal control structure in planning substantive audit tests;
- Ensure that the report contains the following elements:

v. A statement that the intermediary has audited the provider's Medicare cost report;

w. A statement that the audit was conducted in accordance with GAS;

x. If the report relates to a provider's Medicare cost report, a statement that those standards require the intermediary 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;

y. If the report relates to a home office cost statement or a limited purpose insurance company (LPIC), a statement that those standards require the intermediary to plan and perform the audit to obtain reasonable assurance about whether the Medicare home office cost statement or LPIC is prepared in accordance with Medicare laws, regulations, and instructions;

z. A statement that the Medicare home office, LPIC, or provider is responsible for compliance with Medicare laws, regulations, and instructions;

- Refer to the Medicare cost report audit adjustment report. This is a complete listing, with Medicare cost report references, of all adjustments made to the Medicare cost report. It lists and describes items of material noncompliance referred to in the audit report. The adjustments should be described in sufficient detail to explain the provider's noncompliance;

- Refer to areas selected for audit. Any areas selected for field audit must be listed. This includes, but is not limited to, the categories listed in the front of the CMS national audit program (Chapter 5 for hospitals and Chapter 7 for home health agencies), and the relevant exhibits for the PPS or TEFRA, Chapter 2;

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

The following is an example of a Medicare audit report, including the report on the consideration of the internal control structure of the provider.

The intermediary shall edit the report to fit the particular circumstances of its audit. For example, if it decided that a review of a provider's system of internal control was not applicable, it would use one of the alternative paragraphs to explain its basis. The information on the second page of the audit report referring to internal control would not be applicable and should be eliminated. Conversely, if the intermediary did perform a review of internal control, the alternative paragraphs on page one of the report would not be applicable to its audit. Instead, it would use the language on page two of the report as appropriate.

NOTE: The intermediary shall issue an audit report if it audits a home office cost statement or an LPIC cost statement. While the general format of the following example is appropriate, it would modify the language of the audit report to reflect the type of entity audited. For example, neither a home office nor an LPIC is a provider of Medicare services receiving direct payment from the Medicare program. Therefore, the reference in the second and fourth paragraphs of the example audit report to payment amounts is inappropriate under these circumstances. Similarly, the intermediary would change references to "cost report" to "home office cost statement" or "LPIC statement," as appropriate. Also, it would change any reference made to the "provider" to "home office" or "LPIC".

Form of Report on Audit of Medicare Cost Report

INTERMEDIARY 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 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 intermediary used an alternative paragraph on the previous page.

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 intermediary 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 intermediary 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 intermediary 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 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

60.5.9 - Assembling the Cost Report and All Related Attachments

(Rev. 9, 08-30-02)

A4-4112.5.I

The intermediary shall assemble the documents relating to the Medicare cost report and Medicare audit report(s) in the following order:

- Its transmittal letter to the provider;
- Letter of overpayment collection or check disbursement;
- Notice of program payment;
- Auditor's report(s) for the audit and for internal control structure;
- 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 Medicare cost report.
- U - Form of Report for No-Audit

If the Medicare cost report has been settled without audit, the intermediary shall issue a report with the cost report settlement. An example of such a report follows.

Form of Report on No-Audit of Medicare Cost Report

INTERMEDIARY 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

60.6 - Cost Reports and Auditing of Multiple Provider Institution

(Rev. 9, 08-30-02)

A4-4112.6

Where an institution certified as a hospital has a distinct part certified as a SNF or HHA, it is, in effect, another department of the hospital in which routine extended care or home health care services are supplied. Cost finding in such an institution involves allocation of the institution's costs between providers, e.g., the hospital and the SNF or HHA. Thus, hospital complexes offering hospital-based routine or extended care services or home health care services must complete hospital cost reporting forms for the hospital and hospital cost reporting supplemental forms for the hospital-based SNF or HHA, as appropriate. Separate cost reports may not be filed for the hospital-based components. The audit of such a hospital complex will include the hospital-based components, so that one audit will determine the provider's costs.

60.6.1 - Timing of Audits

(Rev. 9, 08-30-02)

A4-4112.6.A

The intermediary shall settle cost reports within program requirements to meet the audit work plan. When audit work needs to be performed on-site, it shall consider scheduling and planning the work when other auditors are not auditing at the provider's location.

60.6.2 - Time Limit for Reopening Provider Cost Reports

(Rev. 9, 08-30-02)

A4-4112.6.B

Once the intermediary has a final settlement (see PRM, Part I, §2408) based on its determination of the total allowable costs, the time limitation for initiating a reopening of the cost report is three years starting on the date of the Notice of Program Reimbursement (NPR). However, if a hearing determination has been issued, the intermediary shall initiate an opening of the cost report for those issues decided in the appeal, only as directed to do so by the hearing officer.

To reopen a cost report, the intermediary shall initiate it prior to the expiration of the three-year period, and adjust the cost report even though the three-year period has elapsed. If the reopening is not initiated within the three-year period, the determination for the cost reporting period may not be reopened, and the cost report becomes final.

An exception to the time limitation for reopening and adjusting cost reports is in the case of fraud. Where a determination of program payment has been obtained by fraud or similar fault, the intermediary shall reopen and correct the cost report at any time. (See PRM, Part I, §2031.1E.)

60.6.3 - Time Limit for Auditing Home Office Cost Statements

(Rev. 9, 08-30-02)

A4-4112.6.C

Since home offices of chain organizations are not providers, their costs are not directly payable. Home office costs are payable only when they are allocated to providers and are part of the provider's allowable costs. The intermediary shall verify the home office costs and equity capital allocated to the provider in its audit of the provider's costs.

Audit of home office costs and equity capital is an extension of the audit of provider costs. The time limit for auditing the home office cost statement is related to the time limit for auditing provider cost reports. Home office cost statements may be audited as long as the cost reports of one or more providers in the chain are within the time period permitting reopening. (See PRM, Part I, §2930.) When the time limits for reopening cost reports of each provider in the chain have expired, the intermediary shall not audit the home office cost statement for that year.

Since the allocation of home office costs and equity capital usually affects all providers in the chain, the audit of the home office cost statement is made by the intermediary responsible for auditing the home office, as soon as possible after its receipt. This avoids the possibility that reopening of related provider cost reports may be prohibited. When the intermediary begins an audit of a home office cost statement, it notifies all other intermediaries that service providers within the chain. It identifies the chain and states the period(s) under audit. The other intermediaries determine whether the cost reports of their providers include any part of the period(s) under audit.

If a cost report has been settled, the servicing intermediary notifies each affected provider that the report may be reopened based upon the findings in the home office audit.

60.7 - Exhibit I - Internal Control Questionnaire

(Rev. 9, 08-30-02)

A4-4112.7

INTERNAL CONTROL QUESTIONNAIRE

The intermediary shall complete the following questionnaire only for providers it is going to audit. However, if it determines not to assess a provider's internal control structure it shall not complete the Internal Control Questionnaire. At its discretion, it shall complete the questionnaire for new providers or first time audits. Furthermore, where CMS directs it to perform a special, focused audit, CMS may limit or require no work in the area of internal control.

This questionnaire is effective for audit fieldwork started after November 30, 1990. However, the questionnaire is not required for "no audits" (which is now defined as less than 40 hours onsite at a hospital), reopenings, or audits of specifically selected areas such as intern/resident costs or wage index reviews.

The intermediary shall answer all questions on the questionnaire "Yes," "No," or "Not Applicable," as appropriate. It shall indicate whether the answer was obtained by inquiry, investigation, or both. It shall provide both name and title of the person

supplying the information to it. 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, the intermediary shall not write an overly detailed description of the procedures.

If some internal control procedures other than those stated or implied by the questionnaire exist and affect the Medicare audit, a description or explanation should be included on a supporting working paper.

The questionnaire is not all-inclusive and may be supplemented according to the needs of the provider being audited.

Once the information required by the questionnaire has been obtained initially, the intermediary shall review and update the questionnaire answers and documentation with the provider for each subsequent audit. It shall obtain the provider's written concurrence to the answers and documentation as a whole or on a question by question basis, as appropriate.

It shall maintain the internal control questionnaire with all related documentation in a separate section of the permanent file. This includes proper references to support audit working papers, if necessary.

60.7.1 - Definition of Internal Control Structure

(Rev. 9, 08-30-02)

A4-4112.7.A

An entity's internal control structure consists of the policies and procedures established to provide reasonable assurance that the entity'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.

This internal control questionnaire reflects those elements of internal control structure that are more relevant to the outcome of a Medicare audit.

60.7.2 - Gaining an Understanding of the Provider's Internal Control Structure

(Rev. 9, 08-30-02)

A4-4112.7.B

The AICPA field work standards and GAS require that:

- A sufficient understanding of the internal control structure is to be obtained to plan the audit and to determine the nature, timing, and extent of tests to be performed.

This means that the auditor must have an understanding of the provider's internal control structure in order to properly plan the audit tests to be done. The understanding enables the auditor to make informed decisions on which assertions of the provider are subject to a high degree of control risk and on which assertions to place reliance.

60.7.3 - Internal Control Questionnaire

(Rev. 9, 08-30-02)

A4-4112.7.C

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				
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				

	Question	Source	Initials	Response	WP Ref
	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 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				

Question	Source	Initials	Response	WP Ref

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:

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?

Question	Source	Initials	Response	WP Ref

B. Guidelines for controlling expenditure functions, such as purchasing and travel authorization?

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

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.

1. Patient days (including observation bed days).

Question	Source	Initials	Response	WP Ref

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?

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.

Question	Source	Initials	Response	WP Ref

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, 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?

Question	Source	Initials	Response	WP Ref

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 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:

Question	Source	Initials	Response	WP Ref
A. What are the provider's formal capitalization and depreciation policies? Obtain a copy.				
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?				

60.8 -General Medicare Audit Policy for the Five Part Process

(Rev. 9, 08-30-02)

A4-4112.8

Prior planning, open communication, and clarifying expectations of all parties results in a smoother and more efficient audit process. The five-part process that follows should enable the intermediary to resolve a significant number of audit issues related to documentation. In addition to improving the actual audit by resolving more issues, it will also directly impact the appeals process by providing better provider understanding of the issues and requirements.

60.9 - The Medicare Audit Process

(Rev. 9, 08-30-02)

A4-4112.9

The audit process contains the following features:

60.9.1 - Audit Confirmation Letter and Preliminary Information Request

(Rev. 9, 08-30-02)

The intermediary shall use an Audit Confirmation Letter and Preliminary Information Request for all audits. Exhibit I is a suggested format that it can modify to suit its particular circumstances. 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 intermediary intends to review during its audit. An entrance conference agenda and exit conference format are also included and are to accompany the intermediary's Audit Confirmation Letter.

1. Timing

The intermediary shall send the Audit Confirmation Letter to the provider so that it is received approximately two weeks prior to the beginning of the intermediary's field audit.

2. General Characteristics

The Audit Confirmation Letter should be provider specific and include the following features:

- Related to issues scoped for audit;
- Not a duplicate request for information that is already in the permanent audit file
- Allow the intermediary's organization flexibility to modify its audit as necessary:
- Contain proposed agendas for the entrance and exit conferences; and
- Detail the information that will be needed to complete the audit of the provider.

3. Information Requested

The intermediary shall develop its own written format for communicating to providers the areas of emphasis in the audit, the audit steps to be performed, what information and documentation is required, and why the information is needed. It shall send this information to the provider in the form of an attachment to accompany its Audit Confirmation Letter. A specific example of this attachment is not included, as the intermediary should develop its own format. However, it shall use clear and concise explanations so that providers fully understand what is expected.

60.9.2 - Entrance Conference

(Rev. 9, 08-30-02)

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 intermediary 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), provider consultants. The intermediary shall consider the following in developing the entrance conference agenda and meeting format:

1 - Timeframes.

- The intermediary shall discuss, if necessary, the need for additional time to provide information requested in the Audit Confirmation Letter;
- The intermediary shall provide an estimate of the time that auditors will spend on site; and
- The intermediary shall discuss timeframes for conducting the audit, scheduling the exit conference, and its provider's responsibilities for conduct and protocol at the exit conference

2 - Other Discussion Topics.

- The intermediary shall 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;
- The intermediary shall give the provider an opportunity to explain what information requested in the Audit Confirmation Letter they can and cannot provide. It shall explore alternative supporting documentation or ways to gather the supporting documentation with the provider representative; and
- The intermediary shall discuss all of its proposed review and clerical review adjustments with the provider. This allows the provider to gain an understanding of issues and provide additional documentation or ways to gather the supporting documentation during the intermediary's onsite field audit.

3 - Intermediary and Provider Administrative Issues.

- The provider liaison should be identified by the provider and fully discuss the liaison's role to ensure full cooperation during the audit.
- The intermediary shall discuss administrative issues such as location of working space for the auditors, use of copiers, its need to make long distance telephone calls, if necessary, and access to fax machines and files.
- The intermediary shall encourage the third party cost report preparer to be available during the course of the audit and exit conference.

60.9.3 - Auditing Process

(Rev. 9, 08-30-02)

One of the most important features of the process is the designation of a provider staff person to serve in the role of the audit liaison. This person assures that the 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

In carrying out its responsibilities, the intermediary's principal goal is to arrive at a correct settlement of the cost report. In doing so, it shall preserve both the provider's interest and government's interest. If its audit uncovers circumstances in which a provider has inadvertently disadvantaged itself, it shall advise the provider accordingly. It shall use the provider liaison to discuss issues of this nature. During the audit, it shall maintain ongoing communications by meeting regularly with the provider liaison to handle the following:

- Documentation that was not requested in the intermediary's entrance letter or requested during the entrance conference;
- Follow upon intermediary 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. The intermediary shall provide audit liaison with the audit adjustments and the related workpapers during the course of the audit.

60.9.4 - Exit Conference

(Rev. 9, 08-30-02)

The provider is entitled to an exit conference, but it may waive this right if it desires. At its entrance, the intermediary shall determine the timing and expectations of the exit conference, and discuss the exit conference format. Persons attending 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. Specific exit conference requirements are as follows:

- The intermediary shall make available the proposed audit adjustment report along with the applicable workpapers, if they were not provided during the audit;
- The intermediary shall develop mutually agreeable arrangements, including timeframes, for the provider to obtain intermediary audit workpapers, if they wish to review them at a later date;
- The intermediary shall attempt to develop an agreed upon resolution for unresolved issues with specific actions required by it and the provider; and
- The intermediary shall ensure that the provider understands that if they do not respond within the agreed upon timeframes, the audit adjustments will be made.

60.9.5 - Post Exit Period

(Rev. 9, 08-30-02)

The post-exit period is the period of time between the exit conference and the issuance of the Notice of Program Reimbursement (NPR). For issues where agreement is not reached, continuing dialogue is encouraged. In certain instances the intermediary may need to request an exception to the Contractor Performance Evaluation Program (CPEP) standard pertaining to the finalization of a cost report. In order for a cost report to be excluded from the CPEP standard, the intermediary must provide its rationale and obtain prior approval from its regional office (RO). This allows the intermediary time to resolve most, if not all, documentation issues prior to final settlement and issuance of the NPR.

During this exit period it is to:

- Respond to all additional documentation submitted by the provider by the agreed upon date, and
- Identify all new or modified audit adjustments on the proposed audit adjustment report that were changed or added subsequent to the exit conference by indicating the date of change.

60.9.6 - Evaluation Process

(Rev. 9, 08-30-02)

To evaluate the effectiveness of this new process a draft evaluation form was developed. The form is divided into intermediary and provider sections. The intermediary shall give the provider a copy of the draft evaluation form at the beginning of the audit. Completion is encouraged but not mandatory. Providers should submit the evaluation document to:

Healthcare Financial Management Association (HFMA)
1050 17 11. St. NW, Suite 700,
Washington DC 20036.

The national office of HFMA will send copies of the completed forms to the local HFMA chapter presidents. If the provider completes the evaluation, the intermediary shall request a copy so that it may be aware of provider concerns stemming from the audit. (However, provider submission to intermediaries is optional).

60.10 - Exhibits

(Rev. 9, 08-30-02)

Exhibit 1 - Audit Confirmation Letter and Preliminary Information Request

Date

Addressee

Address

City, State Zip Code

RE: Audit Confirmation Letter And Preliminary In Formation Request

Provider_____

Provider No:_____

F.Y.E.:_____

Dear _____

This is to confirm our _____ (date) telephone conversation with _____ (name) regarding the planned field audit of your _____ (F.Y.E.). Medicare cost report. During the conversation we agreed the field audit will begin on_____ (date). Workspace will be provided for auditor(s) for a period of ____ weeks.

The entrance conference is set to begin at Time and will be conducted at the _____ (place) site. As discussed, your designated staff and or consultant(s) are to be present at this meeting.

In order to improve the auditing process for all parties involved. We have enclosed a listing of the items we need to have available at the time of the entrance conference and during the field audit. We have specified the major areas we intend to review during this field audit and we have included a brief explanation of why we are reviewing the listed areas

We may request additional documents or information during the field audit on an as-needed basis. Our requests will be in writing and we will make ever effort to give your assigned contact person as much advance notice as possible.

During the course of the field audit, we will provide you with copies of our proposed audit adjustments and supporting work papers. This will enable review and possible resolution of any open or contested issue(s) prior to the exit conference.

The date of the exit conference will be established during the entrance conference meeting. Enclosed are the Entrance and Exit Conference Agenda sheets.

Should you have any questions or concerns regarding our scheduled audit, please call me at (_____) _____ (phone number) or _____ (name), _____ (title), (_____) _____ (phone number).

Sincerely,

Signature, Title

Enclosures

cc:

Exhibit II - Items Needed for the Audit Entrance Conference

Provider_____

Provider No: _____ FYF _____

F.Y.E.: _____

1. Identify changes to the Chart of Accounts (i.e., new accounts).
2. Current Organizational Chart.
3. General Ledger and Working Trial Balance (used to complete the cost report).
4. Obtain a reconciliation of the working Trial Balance (used to complete the cost report.
5. Schedule of Standard Charges for visits/routine services and ancillary services.
6. Detailed schedule of depreciation showing Life, Method, Asset Cost and Accumulated

7. Depreciation. If book depreciation differs from Medicare depreciation, reconciliation is needed.
8. Work papers used in the preparation of the cost report.
9. CPA adjusting journal entries with supporting detail for major items.
10. CPA Management Letter for the year under audit.
11. Minutes of Board of Directors Meeting.
12. Copy of facility license. (Option)

Exhibit III - Entrance Conference Agenda

Intermediary Name

_____

Provider Name:

_____

Provider No.: _____ FYE _____

Auditor: _____Date: _____

Time: _____ Location _____

Provider Representative:

_____

Intermediary 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 share other information.

_____
_

_____
_

4. Establish administrative procedures for such things as:

aa. Use of copy machine _____

bb. Telephone calls _____

cc. Use of copy machine _____

dd. Work hours _____

ee. Parking _____

ff. Working space _____

gg. Other _____

5. Establish procedures for obtaining documents and records and return of same when the auditors have completed their review.

_____

_____

_____

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

_____

_____

_____

7. Discussion of proposed adjustment, if any , to current year's cost report identified during the clerical and desk reviews performed by the fiscal intermediary.

_____

_____

_____

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 exit conference and discuss exit conference agenda.

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

_____

_____

_____

13. Discuss and update the Internal control Questionnaire

_____

_____

_____

14. Other questions asked during the entrance conference.

_____

_____

_____

15. Agenda items from provider (if any)

_____

_____

_____

Exhibit IV - Exit Conference Format

Intermediary
Name_____

Provider Name:

_____

Provider No: _____ FYE:

_____

Auditor; _____Date: _____

Time: _____Location: _____

Provider Representative:

_____

_____

_____

Intermediary 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. Proving documentation to auditors

_____

_____

b. Provider responding to proposed audit adjustments.

_____

_____

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

_____

_____

d. Receipt of final adjustment.

_____

_____

e .Intermediary to provide adjustment workpapers as requested by provider

_____

_____

5. Assure all provider records are returned.

_____

_____

70 - Audit Responsibility for Home Office Costs of Chain Organizations

(Rev. 9, 08-30-02)

A4-4113

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.

Ordinarily, the intermediary responsible for determining the amount payable to the provider and for auditing its records is responsible for auditing the home office to verify the validity of the costs allocated to the provider by the home office. However, where more than one intermediary services providers that are members of the chain, this could result in duplication of audit expenses and inconvenience to the home office. As a basic policy, the intermediary shall make only one audit of the costs of the home office for each accounting period it operates under the program.

70.1 - Single Intermediary Servicing All Providers in Chain

(Rev. 9, 08-30-02)

A4-4113.1

Where one intermediary is servicing all providers in the chain, it is responsible for the audit of the home office costs. It obtains a statement of home office costs from the home office, prepared in accordance with the PRM, Part I, §§2150ff., setting the allowable costs and their allocation to the entities in the chain. The intermediary shall audit the statement of costs to assure that allowable costs, and the equity capital of the home office, have been determined and allocated to the providers in accordance with applicable program policies.

70.2 - More Than One Intermediary Servicing Providers in Chain

(Rev. 9, 08-30-02)

A2-4113.2

Where two or more intermediaries are servicing different providers in the chain, one of the intermediaries (as determined under §70.3) is responsible for auditing the home office. The responsible intermediary obtains from the home office a statement of its costs, including a schedule of its equity capital, prepared in accordance with the PRM, Part 1, §§2150ff., setting the allowable costs and equity capital and their allocation to the entities in the chain. The intermediary shall determine the audit of the statement of cost in accordance with §70.4.

The responsible intermediary requests from the other intermediaries any information its auditors need.

The other intermediaries forward to the responsible intermediary any information they have concerning 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 intermediary should be aware of, or should consider during the audit. In addition, each forwards to the home office responsible intermediary a statement of those costs, cost situations, or transactions, and recommends the scope of examination to be performed in particular identified areas, which it wants the responsible intermediary to examine.

Where the intermediary responsible for the home office audit changes, the outgoing intermediary makes available to the incoming intermediary copies of pertinent prior

years' statements of home office costs, desk reviews, audit reports and audit adjustments, and any workpapers or documentary material pertinent to the current year's audit.

Where the audit firm performing the home office audit changes, the responsible intermediary supplies the new audit firm with all materials and reports that may be pertinent to the upcoming audit.

Any issues relating to the determination and allocation of home office costs, including any provider appeals, are resolved by the responsible intermediary. Prior to the finalization of the audit findings, it forwards the audit results to the other intermediaries that service providers of the chain. However, where an involved intermediary does not agree with an interpretation of application of a policy by the responsible intermediary, it may request the responsible intermediary to obtain an interpretation from CMS. Where such an interpretation is requested, the responsible intermediary delays resolution of the specific issue pending CMS's reply.

At completion, the intermediary performing the audit distributes to the others the audited statements of home office costs and equity capital showing the amounts allocated to each provider. It includes a schedule of adjustments made with a full explanation for each.

The results of the audit are binding upon all intermediaries. They rely upon the audit as support for the home office costs allocated to each provider they service. They make appropriate adjustments to the provider's cost report based upon the report form the responsible intermediary and proceed to make settlements with their providers.

70.3 - Designation of Home Office Audit Responsibility Where Two or More Intermediaries Service the Chain

(Rev. 9, 08-30-02)

A4-4113.3

Where more than one intermediary services the providers of a chain organization, CMS designates the intermediary responsible for the audit of home office costs.

In making this determination, CMS may consult with the RO and the intermediaries and consider such factors as geographical location of the home office, number of providers serviced by each intermediary, total amount of reimbursement to the chain by each intermediary, and other relevant factors.

When CMS has determined which intermediary is responsible, it communicates its decision in writing to all intermediaries and ROs servicing the home office or an individual provider. If the intermediaries servicing the providers prefer to have a different intermediary perform the audit, they may request CMS to assign the audit responsibility to another intermediary. CMS notifies the intermediaries, in writing, of its decision.

70.4 - Scope of Home Office Audit

(Rev. 9, 08-30-02)

A4-4113.4

Although in some cases CMS designates the intermediary responsible for the audit of a home office, it is the designated intermediary's decision of whether or not to perform it. The designated intermediary also writes the scope of the audit. The designated intermediary desk reviews the statement of home office costs, and considers the information furnished by the other intermediaries. Based upon the desk review, consideration of its experiences with the chain organization and the experiences of the other intermediaries, it makes a determination of the need for, and extent of, an audit of the home office costs. However, where less than a full scope examination is to be made, it forwards to all intermediaries servicing the chain, a copy of the audit program being used. It keeps the other intermediaries informed, in writing, of the progress made and of any significant developments.

80 - Provider Records Maintained In Home Office

(Rev. 9, 08-30-02)

A4-4114

Chain organizations carry on their operations with varying degrees of centralization of their provider financial records. Whatever the degree of centralization, the intermediary responsible for auditing home office costs is also responsible for auditing any provider records maintained at the chain home office, upon request of the intermediary servicing the provider.

The effect is to have only one audit of records maintained in the chain home office.

A - Responsibility of Intermediaries Servicing Chain Providers

(Rev. 9, 08-30-02)

The servicing intermediary desk reviews the cost report of its chain provider to determine whether an audit of the provider's cost report is necessary. If it is, it identifies specific areas of costs to be audited. It gives priority to its desk review of the chain provider cost report and submits its audit request within 180 days after the close of the provider's reporting year to the intermediary responsible for the audit of the home office.

The servicing intermediary's written request for audit includes:

- Scope of the audit to be performed;
- Specific areas to be audited;
- Results of the desk review(s); and
- The cost report of the provider.

B - Responsibility of Intermediary Auditing Home Office

(Rev. 9, 08-30-02)

The responsible intermediary reviews the data submitted and, should the need arise, requests necessary additional data. The submitted data provides the basis for the

responsible intermediary to determine the audit time required to comply with the requests for audit, to determine the audit steps necessary, and to schedule the audit. When it schedules the audit, it notifies the servicing intermediary(ies). Copies of both the request and notification of scheduling are sent by each intermediary to its RO.

Whenever possible, the responsible intermediary schedules the audit of the provider records at the home office at the same time it performs the audit of the home office costs. In any event, however, the responsible intermediary schedules and completes the requested audits within a reasonable time after the close of the home office accounting year. This allows sufficient time for the servicing intermediary to review any proposed audit adjustments, and issue the Notice of Program Reimbursement to the respective providers.

1 - Adjustments May Affect Other Providers

During the audit, if the responsible intermediary identifies adjustments that may affect other providers that are not being audited, it notifies the servicing intermediaries. After such notification, should the servicing intermediary(ies) decide an audit is needed, they notify the responsible intermediary of the specific areas to be investigated. When audit steps must be done at the provider's site, the responsible intermediary requests the servicing intermediary to perform them. The servicing intermediary forwards the working papers, and the audit findings, to the responsible intermediary.

2 - Completion of Audit

At the completion of the audit, the responsible intermediary forwards the results to the servicing intermediary, which proceeds with the settlement of the cost report. The results include:

- The scope of audit work performed;
- The schedule of audit adjustments with full explanation why they are necessary and their effect upon each respective 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 intermediary pertaining to the audit of centralized provider records are binding upon the servicing intermediary. Should the servicing intermediary have any questions concerning the audit or its results, it resolves the issues with the responsible intermediary before settlement.

However, when the disagreement cannot be resolved, the intermediary disagreeing may request the responsible intermediary to obtain an interpretation from CMS.

In an appeal of provider costs (not including home office costs allocated to it), the servicing intermediary has jurisdiction. The intermediary responsible for the audit assists it in preparing the appeal position paper.

C - Administrative Responsibility of Servicing Intermediary

(Rev. 9, 08-30-02)

In servicing providers of chain organizations, the servicing intermediary performs all responsibilities assigned to it in the usual intermediary/ provider relationship. The servicing intermediary prepares and executes budget requirements for the providers that it services. (See Chapter 1, §10 and Chapter 2, §10.) The responsible intermediary is reimbursed by the servicing intermediary for the costs of auditing provider records maintained at the home office, and for activities connected with a provider appeal.

90 - Provider Permanent Reference File

(Rev. 9, 08-30-02)

A4-4115

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

The intermediary shall establish the required information in the permanent reference files through the use of the Provider Cost Report Reimbursement Questionnaire (Form CMS-339). It reflects necessary information for the normal servicing of the provider's organizational set-up and history, and constitutes a minimum level of provider knowledge. It shall update the information to reflect changes in the provider's operations and financial arrangements, or amendments to the law and resulting revisions to the Intermediary and 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.

90.1 - General Information

(Rev. 9, 08-30-02)

A4-4115.1

A - 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, the intermediary shall 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. It shall document these determinations and retain them in the permanent files.

B - Accounting System

The intermediary shall request any significant modifications to the provider's accounting system as updates to the initial system survey performed when the provider entered Medicare. It shall indicate reliance upon the provider's independent accounting firms' opinions by making reference to them in the permanent reference files.

C - Provider's Organization

The intermediary shall obtain, or develop with the assistance of the provider, an organizational chart. It shall update it where there are significant changes during any cost reporting period.

It shall 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 intermediary responsible for the home office audit.
- Information for nonprofit organization providers to include:

hh. Copy of the Internal Revenue Service certificate of nonprofit status under §501(c) of the Internal Revenue Code; and

ii. 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:

jj. Documentation that the provider consists of several component facilities which provide clearly different types of care; and

kk. Determination that the provider's records have the capability to separate costs and revenues between the various entities of the facility.

D - Floor Plan of Provider's Facility

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

90.2 - Contracts for Services

(Rev. 9, 08-30-02)

A4-4115.2

A - Services Purchased Under Arrangements

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

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

B - Property-Lease Agreements

- The intermediary shall maintain copies of major lease agreements or extracts for all leased parts of the facility. It shall include major movable equipment or other assets.

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

C - Nonpaid Workers

The intermediary shall include:

- A current copy of the agreement or extract between the union of nonpaid workers and the provider;

- Method utilized to determine the value of services they rendered;

- Listing of members of the organization working in the provider's facility;

- Listing of positions they hold;

- Their average number of hours per week by department; and

- A general description of the type of work they performed by department.

D - Provider-Based Physicians

The intermediary shall 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.

The intermediary shall maintain amendments or new agreements. It shall maintain copies of contracts or extracts and results of any analyses performed. It shall have them available for desk review personnel and field auditors.

E - Management and Consultant Services

The intermediary shall 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.

F - Franchise Arrangement

The intermediary shall maintain a copy of the franchise agreement and its 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.

G - Provider's Certified Public Accounting Firm

The intermediary shall maintain the name of the provider's certified public accounting firm.

90.3 - Accounting Policies

(Rev. 9, 08-30-02)

A4-4115.3

A - Capital-Related Costs

The intermediary shall maintain copies of documents that include the areas of capitalization, relifing of depreciable assets, estimated useful lives of depreciable assets and componentized depreciation. It shall 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.

B - Fixed Assets

The intermediary shall 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, the intermediary shall maintain at least a summary of the asset accounts, updated as required. It shall determine if fixed asset accounting is adequate and if depreciation is based upon guidelines included in PRM Chapter I, Part I.

C - Loan or Mortgage Documents

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

D - Exceptions to Reimbursement Limitations

The intermediary shall evaluate provider requests for exceptions to reimbursement limitations (e.g., limitations on coverage of costs). It shall maintain a complete file to support exceptions, exemptions, and classification adjustments.

E - Education Program Approvals

Approved educational activities means formally organized or planned programs of study operated by the staff of the institution. The intermediary shall include current copies of State licenses or professional organization recognition, to support the determination of the acceptance of the program(s).

F - Insurance

The intermediary shall document the allowance of insurance costs regardless of whether they are for commercial, self-insurance, or alternative forms to provide full coverage. It shall 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.

G - Preparation of Cost Reports

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

H - Deferred Compensation or Pension Plan

The intermediary shall 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.

100 - Uniform Provider Statistical and Reimbursement System (PSRR)

(Rev. 9, 08-30-02)

A4-4118.1

The Medicare PSRR provides statistical data accumulated from claims about Medicare dollars remitted by an intermediary to hospitals and other providers. This information is displayed on detail and summary reports, and is produced upon request from authorized work stations. The PSRR system is included in the standard system.

Intermediaries and providers use detail and statistical summary reports year-to-date (YTD) on claim (CMS-1450) activity for accounting and auditing purposes.

Provider Summary Reports are the main output of the PSRR System. (See Chapter 6, §§150-190.) They are produced from the YTD Provider Summary File and contain information required for each provider for cost report settlement and CMS reporting purposes. All data captured by the PSRR system through the last monthly update is included.

Once the appropriate job has been run (either MD411OAR or MD4305AR depending upon reports requested), up to four reports may be produced. The Provider Summary, and DRG Summary (for PPS hospitals) and Outpatient Clinical Lab Reports, (if applicable) will always be produced plus one of the last two listed:

- "Provider Summary Report": Summarizes claims data and other information required for the Medicare Cost Report and CMS reporting purposes.

- "DRG Summary Report": Summarizes PPS data by DRG - Federal Portion, Hospital Specific Portion and Outliers
- "Clinical Lab Report": Summarizes, by HCPCS with Revenue Code, information on total charges billed and total reimbursement
- "Payment Reconciliation Report": Shows the detail for each claim (CMS-1450) accepted by the PSRR system.
- "Control Reports": Shows the results of the user's corrections to the Provider Summary File, Revenue Code Summarization Table, and Provider Table.

If there were errors on the Parameter Selection Card, the Parameter Error Report will be produced. If there are no data for the requested provider, a No Reports Listing will be produced.