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
8		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 8 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. It is a reorganization and compilation of these instructions into a single financial management manual for intermediaries and carriers. Where there are differences in carrier and intermediary requirements, we distinguish to which contractor the instructions apply. This chapter applies only to intermediaries.

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 8 - General Audit Guidelines

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NOTE: Revision 8, the initial release of this chapter, includes a cross reference to the source sections in current manuals. The manual is identified by A1, A2, A3, or A4 for Intermediary Manual Parts 1 through 4; or by B1, B2, B3 or B4 for Carriers Manual Parts 1 through 4. This indicator is followed by a dash and the related section number.

10 - Reworking of Audited Cost Reports for Timely Final Settlements

(Rev. 8, 08-30-02)

A2-2040

The reworking of the cost report after audit, to reflect audit adjustments, is primarily the responsibility of the provider. However, the intermediary may rework the cost report utilizing its personnel, or it may authorize its audit capability to perform this action if the delay in receipt of the adjusted cost report is due to any of the following:

- Experience has shown that the provider has failed to correctly and/or completely rework the cost report as the intermediary advised;
- The provider has not complied with the time frames the intermediary established and the intermediary is unaware of valid reasons for the delay; or
- The provider does not agree with the audit adjustment and does not sign the adjusted report.

The intermediary shall document its determination in advance, and state the reason and amount of time needed to rework the cost report. When the cost report is reworked by an outside audit capability, the intermediary shall charge the expense to the audit subcontract.

Where the provider disagrees with the audit adjustments and refuses to sign the adjusted report, the intermediary shall work the cost report incorporating all proposed adjustments. It shall give the provider an opportunity to submit a written statement enumerating its

objections, and shall include the statement of objections in the cost report. If the provider refuses to submit a statement, the intermediary shall include a statement in the cost report citing the refusal, and shall enumerate, to the extent known, the provider's objections. It shall determine the final settlement, and process the cost report including the adjustment in dispute.

20 - Audit Adjustment Report

(Rev. 8, 08-30-02)

A2-2041

The audit adjustment report provides for a logical order of presentation of audit adjustments arising from the intermediary’s examination of the cost report. In addition, it provides for the description of the audit adjustment as well as the identification of the adjustment amount and where it is to be applied to the revised cost report.

The first page provides space for the signature of a responsible provider official. Other pages provide space, as needed, for additional audit adjustments.

The audit capability is to assure that its adjustment report is prepared in the format of the sample report shown in Exhibit A. The intermediary shall list adjustments in the order of completion of the cost report. It shall group them as follows:

- Trial Balance of Expenses - Cost
    - Reclassification Schedules
    - Adjustment to Expenses
- Cost Apportionment - Statistics
- Other Statistics
- Charges - Cost Allocation
- Charges - Settlement
- Settlement Data
- Adjustments to Financial Statements

With adjustments listed on the report in the order prescribed above, providers may make the necessary revisions to their cost reports in the same sequence as the reports were originally completed.

Cost reports submitted to CMS must include an Audit Adjustment Report and an Audit Adjustment Report Summary.

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

20.1 - Completion of the Audit Adjustment Report

(Rev. 8, 08-30-02)

A2-2041.1

A. Heading - Intermediary shall complete as indicated.

B. Report Reference - Intermediary shall identify the CMS form, page number or schedule, line number, and column number to which the adjustment ultimately applies. For example, reference to Form CMS-2552, Worksheet A, line 6, column 6, Administrative and General (the cost center affected by the application of the adjustment), would indicate an adjustment to remove the rental cost of television sets not part of patient care activity.

   If the provider uses different schedule lines and column numbers, the intermediary shall reference those actually used. It shall note in the report that the references are to the provider's schedule numbers.

C. Adjustment Numbers - Intermediary shall number adjustments consecutively as they are recorded on the adjustment report. Each change must have a separate adjustment number. Thus, while an adjustment to correct a misclassification of charges between two cost centers might have the same narrative description, it would have two adjustment numbers - one for each change proposed. For example, total charges in the X-ray cost center, as submitted by the hospital, include $1,000 of laboratory charges. Therefore, one adjustment shows a decrease of $1,000 in the charges applicable to the X-ray cost center, and an separate adjustment shows an increase of $1,000 in the total charge applicable to the laboratory cost center.

D. Explanation of Adjustment - In this segment of the report, the intermediary shall insert before such group of adjustments a legend identifying the adjustment(s) to be made. For example, it shall insert **Cost Adjustments** preceding adjustments to the trial Balance of Expenses and **Charge Adjustments** before that particular group of adjustments, etc.

   The narrative description of the audit adjustments following the category designation should be brief but adequate enough to: identify the item being adjusted and the reason, e.g., removing nonallowable cost, reclassification, etc. In addition, at the end of the narrative description, it shall indicate the schedule or page number and line where the adjustment will be recorded. For example, reference should be made to form CMS-1562, Schedule A-5, line 2, for an adjustment that removes the rental cost of television not related to patient care.

The narrative description of the audit adjustments should also include appropriate reference to law, regulations, or program policy and procedures.

E. As Reported or As Adjusted

   1. As Reported - Intermediary shall show the amount included in the unaudited cost report for the cost center that will be affected by the adjustment. For example, where the proposed adjustment will change the net allowable cost of the Administrative and General cost center as reported by the provider, the amount shown will be the net expense for cost apportionment as reported for this cost center on form CMS-1562, Schedule A, line l, column 6.

   2. As Adjusted - Where the Administrative and General cost center has previously been adjusted by the audit capability, the intermediary shall insert in this column the amount shown "As Adjusted" for the previous adjustment. Reference should be made to this previous adjustment in the narrative description of the adjustment, e.g., (see adjustment no. l).

F. Increase (Decrease) - Intermediary shall insert the amount of the adjustment. The adjustment amount should be indicated by brackets if it represents a (decrease) of the amount in the "As Reported or As Adjusted" column.

G. As Adjusted - This column is the result of adding or deducting the adjustment amount from the previously reported amount. After all adjustments have been reflected in the adjustment report, the amount shown in this column in the last adjustment made to the specific cost report reference is the amount that will appear on the revised cost report for that reference. For example, the last adjustment to the Administrative and General cost center shows net allowable cost of $147,000 in the "As Adjusted" column of the adjustment report. When the revised report has been completed, form CMS-1562, Schedule A, line l, column 6 will reflect this $147,000 amount.

AUDIT ADJUSTMENT REPORT

Sample Format

Audit Capability: [___] Apportionment Method:

Intermediary: [___] Departmental RCC

[___] Combination (With cost finding)

I have reviewed the following audit adjustment # l through # 14 and agree with the adjustments both in principle and amount. These adjustments will be incorporated in our revised **Statement of Reimbursable Cost** for the period ended ______________.

Provider # ____________________

Provider Name _________________________

Officer Signature ____

Title____Date___________________

Form	Report Reference Pg or Sch	Line	Col	Adj No.	Explanation of Adjustment	1. As Reported or As Adjusted	2. Increase or (Decrease)	3. As Adjusted
Cost Adjustments								
1562	A	1	6	1	To remove rental cost of television sets not part of patient care activity - adjustment should be made to CMS-1562, Schedule A-5, line 2.	$150,000	$(1,000)	$149,000
1562	A	10	6	2	To offset income from sale of scrap - adjustment should be made to CMS-1562, Schedule A-5, line 9.	$30,000	$ (500)	$29,000
1562	A	11	6	3	To adjust inventory to physical count. Adjustment should be made to CMS-1562, Schedule A, line 11,	$400,000	$(1,000)	$399,000
1562	A	1	6	4	To disallow the estimated cost of providing telephone service to patients. Adjustment should be made to CMS-1562, Schedule A-5, line 1 (See adj. no. 1)	$149,000	$2,000)	$147,000
1562	A	31	6	5	To adjust building depreciation to actual. adjustment should be made to CMS-1562, Schedule A-5, line 22.	$56,000	$6,000	$62,000
Cost Apportionment - Statistics								
1562	B-1	6	7	6	To adjust distribution base for laundry & linen service (pounds of laundry).	450,000	(50,000)	400,000
Other Statistics								
1563	1	9B	-	7	To adjust number of HI Program patient discharges	1,300	100	1,400
Charges - Cost Allocation								
1562	C-1	4	1	8	To reclassify charges applicable to laboratory.	$180,000	$(1,000)	$179,000
1562	C-1	5	1	9	Reclassification of X-ray charges	$160,000	$ 1,000	$161,000
Charges - Settlement								
1562	2	4	2	10	X-ray	$30,000	$ 1,000	$31,000
1562	2	5	2		Laboratory	$39,000	$ 2,000	$41,000
1562	2	7	2		Oxygen Therapy	$28,000	$ 1,000	$29.000
					To adjust HI Program charges for hospital-based physician professional component fees			
Settlement Data								
1563	2	21	6	11	To correct amount received from intermediary for current fiscal period	$300,000	$ 5,000	$305,000
1563	2	19	6	12	To adjust bad debts to actual	$ 1,600	$ (100)	$ 1,500

Report Reference								
Form	Pg or Sch	Line	Col	Adj No.	Explanation of Adjustment	1. As Reported or As Adjusted	2. Increase or (Decrease)	3. As Adjusted
1563	3	9	1	13	To adjust amount received from Intermediary - Hospital Plan	$ 400	$ 50	$ 450
1563	3	9	2	14	To adjust amount received from Intermediary - Medical Plan	0	$ 1,000	$ 1,000

20.2 - Minor Audit Adjustments

(Rev. 8, 08-30-02)

A2-2041.2

The purpose of these guidelines is to provide procedures by which the effect of minor audit adjustments on Medicare reimbursement can be determined without requiring a second step-down cost-finding effort. The intermediary will determine, after considering such factors as reasonableness, equity, and materiality, whether a simplified approach to this determination is practical in the circumstances. Since such a determination will need to consider the circumstances peculiar to each facility, and since the above factors will vary significantly with size, type of provider, program involvement, etc., quantitative limitations have not been established.

A "simplified" method that may be employed by hospitals and skilled nursing facilities is described below together with the conditions under which it may be used.

A. Conditions

This method of reflecting audit adjustments may be used provided:

1. The provider approves;

2. The intermediary finds after consultation with its audit capability that this method has resulted in a reasonable and equitable settlement of costs; and

3. The provider has used either the Departmental RCCAC Method of cost reporting or the Combination Method (with regular or simplified cost finding).

B. Description

This method permits the following:

1. The direct distribution of adjustments that are applicable only to revenue-producing departments or nonallowable cost centers (research, fund raising, etc.) to the appropriate department;

2. The allocation of adjustments to nonrevenue-producing departments to the revenue-producing departments and nonallowable cost centers on the basis of developed percentages or in accordance with provider’s statistics appearing on worksheet B-l. In keeping with the simplified approach, if more than one general service department is adjusted, then the percentage method of allocation should be used.

20.3 - Completion of the Audit Adjustment Report for Minor Audit Adjustment (Exhibit A1)

(Rev. 8, 08-30-02)

A2-2041.3

A. Heading - As Indicated

B. Report Reference - Not used for minor audit adjustments

C. Adjustment Numbers - Adjustments should be numbered consecutively as they are recorded on the adjustment report. Each change must have a separate adjustment number. Thus, while an adjustment to correct a misclassification of charges between two cost centers might have the same narrative description, it would have two adjustment numbers - one for each change proposed. For example, total charges in the anesthesia cost center, as submitted by the hospital, includes $1,300 of radiology charges; therefore, one adjustment would show a decrease of $1,300 in the charges applicable to the anesthesia cost center and a separate adjustment would show an increase of $1,300 in the total charges applicable to the radiology cost center.

D. Explanation of Adjustment - In this segment of the report, the intermediary shall insert before each group of adjustments a legend identifying the adjustments to be made.

   The narrative description of the audit adjustments following the category designation should be brief but adequate enough to identify the item being adjusted and the reason; e.g., removing nonallowable cost, reclassification, etc.

   1. Adjustments to Revenue Producing Cost Centers and Nonallowable Cost Centers

      a. Each direct adjustment to a revenue-producing department should be shown separately on the audit adjustment report. For example, a direct adjustment to the operating room cost center would have this cost center listed with an explanation for the adjustment. The amount of the adjustment will be shown in the "Increase (Decrease)" column. All revenue producing cost centers of a facility will be inserted on the audit adjustment report and used in developing the percentages in column 4 of the audit adjustment report. (See §"H.")

      b. Each direct adjustment to a nonallowable cost center should be shown separately on the audit adjustment report. For example, a direct adjustment to the research cost center would have this cost center listed with an explanation for the adjustment. The amount of the adjustment will be shown in the "Increase (Decrease)" column. All nonallowable cost centers of a facility will be inserted on the audit adjustment report and used in developing the percentages in column 4 of the audit adjustment report. (See §"H.")

   2. Adjustments to General Service Cost - The net adjustment to each general service department will have the net adjustment shown in the "Increase (Decrease)" column.

Details as to the specific cost center(s) affected will be shown in this section with an explanation of the individual adjustments.

3. Allocation of Net General Service Adjustment - The net general service department adjustment will be allocated to each revenue-producing department and nonallowable cost center by multiplying the net general service adjustment by the percent developed for each cost center. See Subsection"H" for instructions on the development of these percentages.

Example: - Operating Room

Net general service department adjustment	x	Percent applicable Operating Room	=	Allocation of General Service Adjustment
$2,000	x	34%	=	$680

E. Column 1 - As Reported or As Adjusted

1. As Reported - The intermediary shall show the amount included in the unaudited cost report for the particular cost center.

2. As Adjusted - Where a cost center has previously been adjusted by the audit capability, the intermediary shall insert in this column the amount shown "As Adjusted" for the previous adjustment. Reference should be made to this previous adjustment in the narrative description of the adjustment.

F. Column 2 -Increase (Decrease) - The intermediary shall insert the amount of the adjustment. The adjustment amount should be indicated by brackets if it represents a decrease of the amount shown in the "As Reported" or "As Adjusted" column.

G. Column 3 -As Adjusted - This column is the total of column l and column 2. Totals in this column plus the amount allocated to each department as a result of the allocation of the net general service adjustment should be carried to column l of schedule C. If no adjustments are made for general services, adjusted totals of the revenue-producing cost centers and nonallowable cost centers should be carried to column l of schedule C. The intermediary shall complete schedule C and appropriate "Settlement pages." (CMS-1992, CMS-1751.)

H. Column 4 - Percent - This column has been added only for illustrative purposes. Percentages can be entered in the right margin of the audit adjustment report. To develop the percentages, the intermediary shall use all revenue-producing cost centers and nonallowable cost centers of a facility. It will develop the percentages by dividing the "as adjusted" amount per cost center by the total of the "as adjusted" column for all revenue-producing cost centers and non allowable cost centers.

Exhibit A1 - Audit Adjustment Report

AUDIT ADJUSTMENT REPORT

Sample Format

Audit Capability: [___] Apportionment Method:

Intermediary: [___] Departmental RCC

[___] Combination (With cost finding)

I have reviewed the following audit adjustment # l through # 14 and agree with the adjustments both in principle and amount. These adjustments will be incorporated in our revised **Statement of Reimbursable Cost** for the period ended ______________.

Provider # ____________________

Provider Name _________________________

Officer Signature ____

Title____Date___________________

Report Reference									
Form	Pg or Sch	Line	Col	Adj. No.	Explanation of Adjustment	1. As Reported or As Adjusted	2. Increase (Decrease)	3. As Adjusted	4. Percent
Adjustments to Revenue Producing Cost Centers and Nonallowable Cost Centers									
				1	Operation Room - To correct salaries for operating room personnel	196,000	1.200	197,200	34
				2	Delivery Room - To correct salaries for delivery room personnel	73,400	(3,800)	69,600	12
				3	Anesthesiology - To correct anesthesiology costs	16,600	800	17,400	3
					Laboratory	146,000	- - - - -	146,000	26
					Blood	15,000	- - - - -	15,000	4
Nonallowable Cost Center									
				4	Research	122,000	(200)	121,800	21
					To adjust research cost	569,000	569,000	567,000	100
Adjustments to General Service Cost									
				5	Administrative and General - To remove rental cost of television sets not part of patient care		(1,000)		
				6	Depreciation - To adjust for incorrect calculation		3000		
					Net general service department adjustment		2,000		
					Allocation of Net General Service				
Adjustments:									
				7	Operating Room	197,200	680	197880	
				8	Delivery Room	69,600	240	69,840	
				9	Anesthesiology	17,400	60	17460	
				10	Laboratory	146,000	520	146,520	
				11	Blood	15,000	80	15,080	
				12	Research	121,800	420	122,220	
						567,000	2,000	569,000	

Note: Column 4 and other column numbers have been added for illustrative purposes.

30 - Instructions to Auditors Engaged or Employed by Intermediaries to Audit Providers Participating in Medicare

(Rev. 8, 08-30-02)

A2-2060

Intermediaries should make sure that persons participating in provider audits under Part A or Part B of the Medicare program are furnished with a copy of the following guidelines. This includes intermediary employees performing audits of providers as well as audit firms engaged by the intermediary.

A. The Health Insurance for the Aged Program (Title XVIII of the Social Security Act as amended) stipulates that Providers - namely hospitals, skilled nursing facilities, home health agencies, and outpatient physical therapy providers - furnishing services to beneficiaries under the Program, will be reimbursed on the basis of the reasonable cost of such services. To facilitate the making of payments to Providers, the Act provides for the Secretary of Health and Human Services (hereinafter referred to as the Secretary) to enter into agreements with public or private organizations to act as Intermediaries for the purpose, among others, of determining the amount of reimbursement to be made to Providers. Reimbursement is made directly by the Intermediaries during the year on an estimated basis, and final settlement is based on audited statements of Providers' cost submitted on an annual basis.

B. The Secretary has overall responsibility for carrying out the Program including prescribing or approving regulations and guidelines to be followed by auditors engaged or employed by Intermediaries to audit Providers' costs. The Secretary has delegated to the Centers for Medicare & Medicaid Services (CMS) the responsibility for policy formulations and the general management and operational aspects of the Program, including the prescribing of principles of reimbursement and related policies for use by Providers in determining the reasonable cost of services furnished to beneficiaries.

C. The purpose of these instructions is to set forth the standards and guidelines to be observed and followed in making audits of Providers' costs, and to prescribe the minimum scope of audit and contents of audit report required.

D. Audits of Provider costs may be made by qualified employees of the Intermediary or by independent audit firms engaged by the Intermediary. The term "independent audit firm" as used in these instructions means (l) an independent certified public accounting firm or independent licensed public accounting firm whose partners or principals are certified or licensed by regulatory authority of a State or other political subdivision; or (2) an organization other than a certified public accounting firm or licensed public accounting firm specializing in the audit and examination of Provider costs. The audit conducted by the staff of the Intermediary or the Intermediary's audit firm will not be deemed to be independent if, during the period of audit or at the time of certification of the reimbursable cost statement, any member of the Intermediary's audit staff or any

employee of the Intermediary having direct jurisdiction or influence over the audit staff of the Intermediary or any partner or principal of the audit firm (l) had, or was committed to acquire, any direct financial interest or indirect material financial interest in the provider, or (2) at the time of audit or during the period covered by the cost statement was an officer or key employee of the provider. In determining the independence of the intermediary's audit employees or the audit firm engaged by it, the word "independent" will be used in the same sense as prescribed by the American Institute of Certified Public Accountants in Rule l.01 of Article l of the Code of Professional Ethics, as amended March 4, 1965.

E. Where an independent audit firm is engaged by the intermediary to audit provider costs, the related contract between the intermediary and the audit firm must meet all requirements prescribed and issued by the Secretary and by the CMS.

F. The independent audit firm's working papers, including permanent files and reviews of internal control, are to be made available to representatives of the Secretary and the intermediary, at all reasonable times, for review and obtaining any necessary information.

   The audit working papers must be retained by the independent audit firm for a period of three years following the final settlement on the audit subcontract. Further, whenever an audit is made by the intermediary's own audit staff, the audit working papers for such audits should be retained by the intermediary for a period of three years following the final settlement for the intermediary's administrative costs for the year in which the audit was made. (See the Medicare Claims Processing Manual, Chapter 1, Records Retention. (MIM-2, §2982, Item 20.))

G. In addition to administering the Health Insurance for the Aged Program, many intermediaries administer hospital and health insurance plans as a part of their regular business and, in connection with such plans, require audits or examinations of providers. Where an audit of provider costs is not made solely to meet the needs or requirements of the program, the intermediary will be required, and may in turn require the audit firm, to maintain documentation to support the reasonableness of the bases used to allocate audit costs attributable to (a) the program aspects of the examination, (2) audit procedures not related to the program, and (3) where audit procedures relating to both the program and to other insurance plans of the intermediary are performed concurrently, the audit costs allocated to the program and to the other plans.

30.l - Audit Standards to be Observed

(Rev. 8, 08-30-02)

A2-2060.1

A - The examination must be in accordance with generally accepted auditing standards and must include, as a minimum, the auditing procedures prescribed in the audit program issued by the CMS and provided to intermediaries for the use of auditors employed or engaged by them. The audit firm may rely on information and instructions supplied by the intermediary regarding such minimum requirements.

30.2 - Questions and Interpretations

(Rev. 8, 08-30-02)

A2-2060.2

The audit firm shall refer questions of interpretations of the Social Security Act, as amended, or principles of reimbursement for provider costs to the intermediary. The audit firm may accept the written reply of the intermediary to the questions as conclusive.

30.3 - Scope of Audit

(Rev. 8, 08-30-02)

A2-2060.3

The audit must be sufficiently comprehensive in scope to permit the expressing in the audit report of an opinion as to whether, in all material respects, the required schedules present fairly the reimbursable costs of the provider in conformity with the principles of reimbursement for provider costs issued by the Secretary.

30.4 - Report on Audit

(Rev. 8, 08-30-02)

A2-2060.4

A - These instructions relating to the report are to be applied by intermediary employees performing audits of providers as well as by audit firms engaged by the intermediary.

B - A separate report on audit must be prepared and submitted, in the required number of copies, to the intermediary, promptly upon completion of the examination of each provider. The intermediary will submit one copy of the report to the CMS.

C - The audit report is to include, as a minimum, the following sections and items:

1. Statements

   Providers' statements of reimbursable costs, on the forms prescribed by CMS. (See Exhibits 6 and 7.)

2. Auditor's Certificate

   A. The certification should, depending on the circumstances, conform to the forms included in Exhibits 6 and 7 and the reporting requirements outlined in Exhibits 6 and 7 are to be considered as part of these instructions.

   B. Notwithstanding any provisions to the contrary, if the intermediary instructs the audit firm to perform so limited an audit that the audit firm is not able to express an overall

opinion as to the fairness of reasonable costs, then the report of the audit firm to the intermediary shall be limited to a summary of the audit work actually performed and a listing of any matters noted in such examination which would reflect on the fairness of reasonable costs.

3. Auditor's Comments

One of the important functions of the intermediary is to assist its providers. Auditor's comments are required so that the intermediary's attention is called to any matters that appear to be in need of improvement in a provider's management, operations or its accounting system.

In these comments a statement must appear concerning whether or not the auditor detected any questionable practices on the part of the provider that suggest the need for further investigation. Specifically, the auditor's notes must include the following statement:

"During the course of the audit I detected (or did not detect) practices on the part of the provider that are inconsistent with sound fiscal or business practices and that may result in unnecessary cost to the Medicare program."

The auditor must also include a comment if it is determined that a provider has claimed costs for any noncovered items or services that were disallowed on a prior cost report. (See §30.5 for additional instructions.)

In addition, the auditor must comment on the provider's accounting and internal control systems as they affect the development of cost data under the prescribed principles of reimbursement. When the audit report contains a qualified opinion or a disclaimer of opinion, the comments should disclose the deficiencies that resulted in the qualified opinion and offer suggestions for improvement.

If the auditor finds that the provider is not complying with cost report related directives issued by the intermediary of CMS to a degree affecting the economical or effective operation of the program, the instances of noncompliance should be discussed in the comments.

An audit firm may elect to issue a report containing the auditor's comments, findings, and recommendations on matters other than the provider's statement of reimbursable costs. Such a report should be separate from the audit report of the provider's statement of reimbursable costs. Both reports should be submitted to the intermediary at the same time if possible. If not, the separate report must be submitted within 30 days after the submission of the audit report.

When the auditor finds that the directives issued by the intermediary or CMS do not provide adequate or effective instructions and guidelines to the provider or that the assistance furnished the provider has been inadequate or ineffective, the findings and recommendations for improvement should be included in a separate memorandum to the intermediary.

30.5 - Notification to OPI RO of Suspected Fraud or Abuse Cases

(Rev. 8, 08-30-02)

A2-2060.5

A - If the intermediary/subcontractor auditor identifies a potential fraud or abuse situation, the auditor should immediately notify the intermediary, which, in turn, alerts the OPI RO.

The following are examples of the appearance of a potential fraud or abuse:

1. Recording of personal expense items as provider cost for patient care.

2. Arrangements by providers with employees, independent contractors, suppliers and others that appear to be designed primarily to overcharge the health insurance program with various devices e.g., commissions, fee splittings, used to siphon off or conceal illegal profits.

3. A pattern of overutilization of services to inflate charges for purposes of increasing reimbursement.

4. Any evidence of payroll entries and disbursements to personnel who provide little or no services to the provider.

5. Providers' concealment of business activities which would affect eligibility for, or amount, of Providers' concealment of business activities that would affect eligibility for, or amount, of program reimbursement, e.g., undisclosed change of ownership or relationship with a supplying organization.

6. Falsifying provider records in order to appear to meet the conditions of participation.

7. Charging to the health insurance program costs not incurred or which are attributable to nonchargeable services or nonprogram activities.

8. Billing for supplies or equipment that are clearly unsuitable for the patient's needs or are so lacking in quality or sufficiency for the purpose as to be virtually worthless.

9. Duplicate billing which appears to be deliberate. This includes billing the Medicare program twice or billing both Medicare and the beneficiary for the same services.

10. Deliberately providing, or receiving health insurance payments on the Medicare account of other than the individual to whom the account belongs.

11. Persistently and deliberately billing beneficiaries rather than Medicare for covered services.

12. Soliciting, offering or receiving a kickback, bribe or rebate.

13. An ineffectual board of directors and/or audit committee.

14. Abuse of internal accounting controls by administrative personnel.

15. Indications of personal financial problems of administrators.

16. Significant changes in business practices.

17. Inadequate working capital or lack of flexibility in debt restrictions such as working capital ratios and limitations on additional borrowing.

18. A complex corporate structure where the complexity does not appear to be warranted by the provider's size.

19. Frequent changes of legal counsel or of key financial officers such as treasurer or controller.

20. Premature announcement of profit or loss or of future expectations.

21. Significant fluctuations in material account balances, financial Inter-relationships, inventory variances or inventory turnover rates.

22. Unusually large payments in relation to services rendered by lawyers, consultants, agents and others.

23. Difficulty in obtaining audit evidence with respect to unusual or unexplained entries, incomplete or missing documentation, or alterations in documentation or accounts.

24. Delays in responses or evasive responses by management to audit inquiries.

25. Deliberately including cost, without disclosing the fact, in the provider cost report, that specifically is nonreimbursable under the Medicare 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.

B - Where a questionable situation has been identified, it would ordinarily be appropriate for an audit to be conducted while the situation is being investigated by the Office of Program Integrity and/or the Office of the Inspector General. Occasionally, however, circumstances may require that an audit be discontinued pending the results of the investigation. CMS and the Office of Inspector General will decide these questions. **Under no circumstances should the auditor discuss a possible fraudulent or abuse situation with the provider or take any action to resolve such questionable situations prior to receiving instructions from the CMS Regional Division of Quality Control.** In addition, no action to disallow questionable costs involving possible fraud or program abuse should be taken without specific instructions from the CMS Regional Division of Quality Control.

C - The intermediary has the responsibility of providing necessary guidance to providers in preparing their cost reports. If certain cost items are discovered, during an audit or desk review, that are nonallowable, it shall make the necessary adjustments and inform the provider of them.

Additionally, the intermediary should document any adjustments made to the cost report involving nonallowable cost items.

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

If these same nonallowed costs appear on a subsequent cost report, the provider should be told again why these costs were disallowed. The intermediary shall confirm the results of such notification in a letter advising 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 following model language may be used:

> "On our audit for the period _____________ to ____________ certain cost items were disallowed because they were determined by our auditors to be nonallowed 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 meeting last week we advised you which specific items were not allowed and the reason for the disallowance. Further insistence on including these nonallowable costs in future cost reports could result in 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 on its cost report prepared after receipt of the letter, the intermediary shall refer the case to the Office of Program Integrity Regional Office.

The above instructions do not apply where the allowability of a cost item has been disputed, and the provider clearly indicates on the subsequent cost report that this particular item is still disputed and is being included by the provider in the cost report only to establish the basis for an appeal.

40 - Exhibits

(Rev. 8, 08-30-02)

A2-2065

Exhibit 6: Report of Examinations of Pages 2 and 3 of Hospital Statements of Reimbursable Cost Under Medicare

This report was prepared by the Subcommittee on Compliance Reports of the Committee on Auditing Procedure of the American Institute of Certified Public Accountants.

Exhibit 7: Illustrative Form of Report

This report is applicable to the audit of hospitals. Where audits are made of providers other than hospitals - namely skilled nursing facilities and home health agencies - the forms of auditor's report will conform, in all material respects, to the forms applicable to audits of hospitals.

Changes by the auditor in the forms of report will be confined primarily to substitutions of the appropriate CMS form numbers and page numbers to give effect to the variations in the forms prescribed by CMS for reporting reimbursable costs of each type of provider.

Exhibit 6 - Reports on Examinations of Pages 2 and 3 Of Hospital Statements of Reimbursable Cost Under Medicare

Examinations by independent auditors of information included in Medicare cost reimbursement schedules are expected to be made in varying circumstances. The nature of the records and the effectiveness of internal control will vary among providers. In addition, there will be variations in the scope of the work that the provider's auditors have been engaged to perform. In some cases, the providers' auditors will have examined and reported on both the financial statements and the cost reimbursement schedule. In others they will have examined and reported on only the financial statements. In still other situations the providers will not have auditors. The variations in the circumstances of internal control and in the extent of the auditing procedures performed by any provider auditors will affect the amount of audit work to be done by auditors engaged by the intermediaries.

As in any other examination, the independent auditor reporting on information contained in the cost reimbursement schedule should obtain sufficient evidential matter to form a reasonable basis for their own opinion. In obtaining such evidential matter the auditor should make use of the audit work done by other auditors. The auditor should refer to their working papers and discuss with them the scope of their work and their conclusions. These steps are intended to enable the intermediary-appointed auditor to select the procedures to apply and the tests to make.

In selecting the procedures to be applied and the extent of the testing to be done, the auditor should use to the greatest extent possible the work performed by other auditors, in a manner similar to the use that the auditor makes of highly effective internal control procedures, including any internal auditing procedures performed by members of the providers' staff.

The form of opinion shown below is intended to be illustrative of the opinion that the independent auditors should find it appropriate to give where they have been engaged to examine pages 2 and 3 of the Hospital Statements of Reimbursable Cost (Form CMS-1563).

Illustrative Form of Report

We have examined the information shown on pages 2 and 3 of the Hospital Statement of Reimbursable Cost (Form CMS-1563) of the ______________________ for the year ended _________. Our examination of this information was made in accordance with generally accepted auditing standards, and accordingly included such tests of the accounting and statistical records and such other auditing procedures, including those prescribed in the Audit Program for

Hospitals published by the Department of Health and Human Services, as we considered necessary in the circumstances.

In our opinion, pages 2 and 3 of the accompanying Hospital Statement of Reimbursable Cost present fairly in all material respects the information shown therein, in conformity with the Principles of Reimbursement for Provider Costs published by the Secretary of Health and Human Services applied as described in the notes to those pages.

____

Signature

____

Date

The foregoing form of opinion is appropriate for use by the provider's auditor as well as by the intermediary-appointed auditors who may or may not have examined the provider's financial statements. In circumstances where the provider's unaudited financial statements, in complete or partial form, are shown on pages ____ through ____ of the cost reimbursement schedule, such financial statements should be marked as "unaudited" and a middle paragraph should be added to the report expressing a disclaimer of opinion on the financial statements. Where the financial statements shown on pages ____ to ____have been examined by either (a) the auditor rendering the report on pages 2 and 3 or (b) the provider's auditor a middle paragraph may be added as follows:

As to situation (a):

> We have examined the financial statements of______________________________ for the year ended _________________________ and have rendered our report thereon under date of ____________________.

As to situation (b):

> We have not examined the financial statements of _________________________ ___________________ for the year ended _________________, and accordingly we do

not express an opinion on them. Such statements were examined by other public accountants who have reported on them under date of ___________________.

Since inclusion of the middle paragraph is intended solely to furnish information about any examinations that may have been made of the financial statements included in the cost reimbursement schedule and not to indicate a sharing of responsibility, the opinion expressed as to pages 2 and 3 should not be modified to refer to the middle paragraph.

Whatever the circumstances, as in the case of any engagement where an auditor expresses an opinion, the auditing work done should be sufficient to support the opinion.

50 - Qualifications and Disclaimers of Opinion

(Rev. 8, 08-30-02)

A2-2069

Appropriate modification of the illustrative form will be required when the auditor finds it necessary to qualify their opinion or give a disclaimer of opinion.

There may be situations in which the auditor examining pages 2 and 3 of the Statement of Reimbursable Cost will not be able to formulate an opinion concerning such pages, or items shown on them, either because restrictions were placed on the scope of the auditor’s work by the intermediary or because the condition of the reports prevented the auditor from performing the work.

There also may be situations where the auditor will conclude that information shown is not presented fairly. These situations may concern instances where, for example, the auditor concludes that the pages do not present certain information in conformity with accounting requirements of the Department, or where cost allocations are made improperly or information is inaccurate.

In the above situations the auditor should be guided by the discussion of qualified opinions and adverse opinions in Chapter 10 of AICPA Statement of Auditing Procedure No. 33.

The circumstances which resulted in a qualification of disclaimer of opinion should always be detailed in the auditor's notes. (See §30.5 for additional instructions.)

60 - Special Examinations

(Rev. 8, 08-30-02)

A2-2073

Intermediaries may seek the advice and assistance of auditors with respect to various accounting and auditing matters associated with Medicare. This may include requests for special

examinations, such as examinations of specific accounts of Hospital Statements of Reimbursable Cost examined by other auditors. The form of report to be submitted in such cases should be designed to fit the individual situation and should set forth clearly the scope of the work performed and the results. The auditor should be careful in reporting on such situations that the auditor does not give the impression of having assumed more responsibility than the auditor's special examination warrants. Generally, the provisions of Chapter 13 of the Statement of Auditing Procedure No. 33 dealing with special reports apply to such situations. In some cases "negative assurance" type of reports may be appropriate, provided the conditions described in paragraph 21 of Chapter 10 of Statement of Auditing Procedure No. 33 are met.

70 - Access to Books, Documents, and Records of Subcontractors

(Rev. 8, 08-30-02)

A2-2075

70.1 - General

(Rev. 8, 08-30-02)

A2-2075.1

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

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

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

70.2 - Definitions

(Rev. 8, 08-30-02)

A2-2075.2

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

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

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

D. **Provider -** A hospital, skilled nursing facility, home health agency, hospice, or comprehensive outpatient rehabilitation facility, or a related organization of any of these providers.

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

F. **Related to the Subcontractor** - A subcontractor that is, to a significant extent, associated or affiliated with, owns (or is owned by), or has control of (or is controlled by), the organization furnishing the services, facilities, or supplies. If a provider contracts for services with a subcontractor, and the subcontractor thereafter contracts with a related organization (which will actually furnish the services), both contracts must contain the access clause if one of the monetary criteria, described in the following §70.4, is met.

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

70.3 - Types of Contracts Covered by Access Provisions

(Rev. 8, 08-30-02)

A2-2075.3

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

A. Consultations, management, medical care provided by physician groups or hospital-based physicians (for which Medicare may reimburse providers on a cost basis);

B. Linen services (rental of linens);

C. Furnishing of meals (as opposed to the direct purchase of food);

D. Legal and accounting services;

E. Provider management and provider management information systems; and

F. Insurance and leases for buildings and equipment.

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

70.4 - Monetary Criteria

(Rev. 8, 08-30-02)

A2-2075.4

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

A. Any contract for services for 12 months or less that is valued at $10,000 or more (e.g., a $12,000 contract for services that are completed in 2 months);

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

C. Any contract that runs for more than 12 months, the apportioned value of which is $10,000 or more for a 12-month period (e.g., a contract for 18 months valued at $18,000 (the 12-month value is $12,000) or a contract for 24 months valued at $20,000, the 12-month value of which is $10,000); or,

D. Any contract in which the cost or value of the services or service component is not specified, but the provider-projected services' value is $10,000 or more. (If a contract does not contain the cost or value of the services and does not include the access clause, and it is subsequently determined by an intermediary (or other representative of the HHS Secretary) that the contract is subject to the statute, the provider risks not being

reimbursed for the cost of the services under Medicare unless a good faith showing is made that would permit modification of the contract.)

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

Providers are advised in§2440.4, Chapter 24, Provider Reimbursement Manual (CMS Pub. 15-1), that the following sample access clause language (which complies with the regulation) may be used:

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

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

70.5 - Access Clause Not in Contract

(Rev. 8, 08-30-02)

A2-2075.5

There may be situations where a provider, after applying the criteria of the regulation to a contract, erroneously decides that the contract does not require an access clause. In such unusual situations, if the provider demonstrates satisfactorily that the decision not to include the clause was made in good faith with a reasonable basis(es), and the provider and subcontractor amends its contract to include an access clause within an acceptable (to the intermediary) period of time after being advised that such amendment is required, the intermediary shall treat the contract as meeting the requirements of the regulation. An example of a provider response demonstrating good faith with a reasonable basis is a situation where the provider honestly concluded that the cost or value of the service component of a goods and services contract was less than $10,000. With respect to contracts where services or services and goods are still being provided, any such amendment must make clear that the access clause applies to books, documents, and records for the full term of the contract and not just for the period following the date of amendment. If a provider demonstrates satisfactorily that the decision not to include the clause was made in good

faith with a reasonable basis, but cannot amend the contract because the subcontractor is no longer in business, the intermediary shall make a determination as to the reasonableness of the costs of the subcontractor's services using available information. The intermediary shall take appropriate disallowance and/or recoupment action with respect to the cost of the services of the subcontractor if either the provider or subcontractor refuses to amend the contract, or the provider does not demonstrate satisfactorily that the decision not to include the clause was made in good faith with a reasonable basis(es).

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

70.6 - Reasons for Seeking Access

(Rev. 8, 08-30-02)

A2-2075.6

If a written accusation (from an HHS or non-HHS party) with suitable evidence against a provider or subcontractor of kickbacks, bribes, rebates, or other illegal activities is received, the intermediary shall prepare a report of the situation and forward it to the regional Office of Health Financing Integrity (Office of the Inspector General, HHS). However, if there is reason to believe that the costs claimed by a provider for services of a subcontractor are excessive or inappropriate, or evidence of possible nondisclosure of the existence of a related organization is discovered, or it is determined that there is insufficient information to judge the appropriateness of the cost(s) claimed by a provider for services of a subcontractor, it may be necessary to examine the books of the subcontractor. Before requesting the subcontractor's books, the intermediary shall determine if there is a more efficient, practical, or economical method of obtaining the necessary information. If there is such a method or other source (e.g., the provider is able to furnish substantiation for the cost of the services), the intermediary shall obtain the needed information by that means before seeking to gain access to the subcontractor's books. If there is no alternate method or source, the intermediary shall seek access, but shall limit the access request to those books germane to the item(s) in question. It shall not make any

unnecessarily burdensome or overly intrusive demands on a subcontractor or go on "fishing expeditions."

70.7 - Access Request Procedures

(Rev. 8, 08-30-02)

A2-2075.7

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

A. Reasonable identification of the books to which access is being requested;

B. Identification of the subject contract or subcontract;

C. Reason(s) why the appropriateness of the costs or value of the services of the subcontractor in question cannot be adequately or efficiently determined without access to the subcontractor's books;

D. Authority in the statute and regulations for the access requested (see §70.1);

E. If possible, identification of the individual(s) who will visit the subcontractor to obtain access to the books.

F. Time and date of the scheduled visit; and

G. Name of the duly authorized intermediary staff member to contact if there are any questions.

70.8 - Subcontractor Response Requirements

(Rev. 8, 08-30-02)

A2-2075.8

A. A subcontractor has 30 days from the date of a written request for access to books to make them available in accordance with the request.

B. If a subcontractor believes a request is inadequate because it does not fully meet one or more of the required elements listed in §70.7, it must advise the intermediary of the additional information needed within 20 days from the date of the request. Within 20 days from the date of the intermediary's response (providing the additional information), the subcontractor must make the books available.

C. A subcontractor must request (in writing) an extension of time within which to comply with an access request if it believes, for good cause, that the requested material cannot be made available within the 30 day period (e.g., the requested material is located at a home office or in storage and there will be a delay due to retrieval time). If such a request is made, the intermediary shall either grant an extension for good cause shown or, if no date

can be mutually agreed upon for making the books available, initiate a delay or denial of reimbursement for the cost of the services.

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

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

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

F. A subcontractor must, at the request of an intermediary, make the originals of any requested books available for inspection.

70.9 - Refusal of Subcontractor to Furnish Access

(Rev. 8, 08-30-02)

A2-2075.9

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

70.10 - Freedom of Information Act (FOIA) Requests

(Rev. 8, 08-30-02)

A2-2075.10

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

Centers for Medicare & Medicaid Services

7500 Security Boulevard

Baltimore, MD 21244

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

DETERMINATION OF PROVIDER COSTS

80 - General Instructions for Submitting Cost Report Data to CMS

(Rev. 8, 08-30-02)

A4-4020

The intermediary is required to submit all CMS-2552-81 (11/81) Medicare Cost Reports from hospitals and hospital/health care facility complexes for fiscal years ending on or after January 1, 1982, except as noted below, to CMS in accordance with the Hospital Cost Report Information System (HCRIS) specifications.

The cost report data is used to update the HCRIS database. This database is available to all users authorized by CMS. The intermediary is responsible for responding to CMS inquiries regarding cost report status and data edits. Once a cost report has been accepted into HCRIS, the intermediary is not required to supply to CMS any cost report data including hard copies of that cost report except to comply with §223 cost limitation purposes and ongoing quality control verification. The §223 cost limit data collection effort will operate until HCRIS' ability to meet the 223 cost limit standard has been demonstrated through the validation review as explained in §300.3. Any requests for hard copy cost reports or requests for any data items for special studies or surveys other than for 223 cost limit purposes should be forwarded to:

Centers for Medicare & Medicaid Services
Attention: HCRIS Coordinator
7500 Security Boulevard
Baltimore MD 21244-1850

In general, two submissions of the cost report will be expected for each provider from all intermediaries. The first will be the cost report "as submitted" by the provider after completion of the mathematical accuracy checks and passing of HCRIS edits as defined in Table 2. This submission must be provided to CMS within 180 days of the provider's fiscal year end. (For closed and/or merged providers, the submission must be provided to CMS within 180 days of close or merger.)

The second submission normally will be the cost report after completion of final settlement, with all adjustments included (after Notice of Provider Reimbursement has been issued). This submission must be sent to CMS within 30 days after issuance of the Notice of Final Settlement. If the final settlement is made with no changes to the "as submitted" cost report (as previously sent to CMS), the intermediary uses the Notice of Settlement With No Changes Form (Exhibit 2). Subsequent submissions under HCRIS are required each and every time a settled cost report is reopened and revised subsequent to the submission to CMS of data from the prior final settlement. These submissions are due within 30 days after the date of each final settlement.

90 - Audit Subcontract

(Rev. 8, 08-30-02)

A4-4025

90.1 - Approval

(Rev. 8, 08-30-02)

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

90.2 - Routing of Audit Subcontracts

(Rev. 8, 08-30-02)

The intermediary shall submit proposed audit subcontracts directly to RO servicing its area. If its contract responsibilities extend beyond regional boundaries, it shall submit them as follows:

- Subcontracts by the Blue Cross Plans are submitted by the Blue Cross Association to the RO servicing the area in which the Plan's principal place of business is located.

- Subcontracts originating from other multi-regional intermediaries are submitted to the RO servicing the area in which the intermediary's home office is located.

90.3 - Required Documentation

(Rev. 8, 08-30-02)

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

- Its justification for selecting the proposed audit firm.

- Copies of proposals from one or more additional audit firms.

- A certification by the intermediary to read as follows: our approved budget contains or will contain sufficient funds for the amount requested for this subcontract.

- A statement of its estimated percentage of time and costs, if any, to be shared by third parties.

NOTE: Only that portion of total costs for which Medicare is responsible should be reflected as "Total Medicare Cost."

90.4 - Competition

(Rev. 8, 08-30-02)

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

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

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

100 - Model Audit Subcontract Form

(Rev. 8, 08-30-02)

A4-4026

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

ARTICLE I

Auditing Services

A. General

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

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

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

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

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

1. Audit workpapers detailing work performed which supports the audit findings.
2. Audit adjustments prepared in the format required by the Intermediary, as prescribed by the Centers for Medicare & Medicaid Services (CMS), to be discussed with provider officials. The Audit Firm will be present at these meetings.

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

E. Final acceptance for all work called for herein will be made by the Intermediary when it determines that all technical requirements under the contract have been satisfactorily met. Any

corrections or adjustments necessitated by the Audit Firm's failure to comply with the specifications will be made at no additional expense to the United States Government.

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

ARTICLE II

Compensation for Services Performed Under This Contract

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

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

B. The Intermediary shall reimburse the Audit Firm for all reasonable incurred travel costs in accordance with the guidelines for travel in the Federal Acquisition Regulations (FAR) §31.205-46, as outlined in subparagraphs 1 and 2 below. Travel costs are those expenses for transportation, lodging, subsistence, and related items incurred by any member or employee of the Audit Firm in the performance of functions under this Contract. Such costs may be charged on an actual basis, a per diem or mileage basis in lieu of actual costs incurred, or a combination of the two. The method used shall apply to an entire trip and not to selected days of the trip.

1. Costs incurred for lodging, meals and incidental expenses shall be considered to be reasonable and allowable only to the extent that they do not exceed on a daily basis the maximum per diem rates in effect at the time of travel as set forth in the Federal Travel Regulations.

2. Airfare costs in excess of the lowest customary standard coach, or equivalent airfare offered during normal business hours are unallowable except when such accommodations

require circuitous routing, require travel during unreasonable hours, excessively prolong travel, result in increased cost that would offset transportation savings, are not reasonably adequate for the physical or medical needs of the traveler, or are not reasonably available to meet mission requirements.

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

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

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

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

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

ARTICLE III

Amendments Due to Increases in Charges

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

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

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

ARTICLE IV

Amendments Due to Increase and/or

Decrease in Number of Providers of Service

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

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

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

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

ARTICLE V

Questions and Interpretations

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

ARTICLE VI

Term of the Contract

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

ARTICLE VII

Termination of Contract

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

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

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

ARTICLE VIII

Disputes

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

ARTICLE IX

Appendices

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

ARTICLE X

Contract and Amendment Approval

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

IN WITNESS WHEREOF, the parties hereby execute this agreement this

_______ day of __________ 19 _______.

____

(Audit Firm)

____

____

(Address of Audit Firm)

By: ____

(Signature) (Title)

(Intermediary)

By: ____

(Signature) (Title)

(Blue Cross/Blue Shield Association)

By: ____

(Signature) (Title)

Approved:

Secretary of Health and Human Services

By :___________________________________

Signature
____
(Title)

This____________ day of ____________20____

110 - Appendix A - Hourly Rate of Audit Firm Personnel

(Rev. 8, 08-30-02)

A4-4027

APPENDIX A
HOURLY RATE OF AUDIT FIRM PERSONNEL

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

120 - Appendix B - List of Providers of Services to be Audited

(Rev. 8, 08-30-02)

A4-4028

Appendix B
List of Providers of Services to be Audited

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

130 - Addendum to Subcontract

(Rev. 8, 08-30-02)

A4-4029

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

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

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Section I

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

SECTION I

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

Clause I

FACILITIES NONDISCRIMINATION CLAUSE

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

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

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

"It is agreed that the lessor's noncompliance with the provisions of this clause shall constitute a material breach of this lease. In the event of such noncompliance, the lessee in acquiring

substitute space. Substitute space shall be obtained in as close proximity to the lessor's building as is feasible and moving costs will be limited to the actual expenses thereof as incurred."

"The lessor agrees to include, or to require the inclusion of the foregoing provisions of this clause (with the terms "lessor" and "lessee" appropriately modified) in every agreement or concession pursuant to which any person other than the lessor operates or has the right to operate any facility. Nothing herein contained, however, shall be deemed to require the lessor to include or require the inclusion of the foregoing provisions of this clause in any existing agreement or concession arrangement or one in which the contracting party other than the lessor has the unilateral right to renew or extend the agreement or arrangement, until the expiration of the existing agreement or arrangement and the unilateral right to renew or extend. The lessor also agrees that it will take any and all lawful actions as expeditiously as possible with respect to any such agreement as the contracting agency may direct to enforce this clause, including but not limited to termination of the agreement or concessions and institution of court action."

Clause II

DISCLOSURE OF INFORMATION

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

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

Clause III

AUTOMATIC TERMINATION OF SUBCONTRACT CLAUSE

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

Notwithstanding the following, if the Contractor wishes to continue the subcontract relative to its own business after the contract between the Secretary and the Contractor has been terminated or nonrenewed, it may do so provided it assures the Secretary in writing that the Secretary's

obligations will terminate at the time the Medicare contract terminates or is nonrenewed subject to the termination cost provisions provided for in the contract.

The clause is as follows:

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

Clause IV

LIQUIDATED DAMAGES IN SUBCONTRACTS

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

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

Clause V

PRIVACY ACT

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

Clause VI

COST AND PRICING DATA

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

The Subcontractor is required to submit written cost or pricing data and certify that the data submitted was accurate, complete and current at the time of entry into this subcontract or

modification in accordance with Subpart 15.804 of the Federal Acquisition Regulation and to maintain full and complete accounting records to support cost or pricing data submitted. The Subcontractor must provide for full access by the Contractor, the Secretary, and the Comptroller General of the United States for the purpose of examining the accuracy of cost or pricing data submitted as aforesaid, and in accordance with Subpart 15.804 of the Federal Acquisition Regulation, agrees to a reduction in price if the cost or pricing data submitted is found to be defective.

SECTION II

In addition to the clauses in §I, the clauses contained in §II are also applicable to this subcontract regardless of amount if the subcontract (a) provides for the performance of any of the functions required for the administration of the Medicare agreement between the Contractor and the Secretary, or (b) involves subcontracting for automated data process systems or facilities management services which required the Secretary's prior approval.

Clause VII

SUBCONTRACTING OF RESPONSIBILITIES

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

Clause VIII

INSPECTION

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

Clause IX

RIGHTS IN DATA

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

B. As used in this clause, the term "Subject Data" means writings, sound recordings, pictorial reproductions, drawings, designs, or other graphic representations, all systems documentation, program logic, operational manuals, forms, diagrams, workflow charts, equipment descriptions, data files, data processing or computer programs, all other operational methods and procedures involved in the performance of functions under the subcontract and works of any similar nature (whether copyrighted or copyrightable) which are acquired or utilized by the Subcontractor in carrying out its functions under this subcontract, for which more than 50 percent of the cost of development has been paid out of Government funds. The term does not include financial reports, cost analyses, and similar information incidental to contract administration.

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

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

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

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

G. Deferred ordering and delivery of data. The Government shall have the right to order, at any time during the performance of this subcontract, or within two years from either

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

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

Clause X

SUBCONTRACTOR AS COMMON SUBCONTRACTOR

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

Clause XI

MODIFICATION OF SUBCONTRACT

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

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

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

Clause XII

REGULATIONS AND GENERAL INSTRUCTIONS

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

Clause XIII

PROHIBITION AGAINST BILLING SERVICES

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

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

equipment) for a provider as long as operating such a billing service does not require the Subcontractor to describe or code the health-care services being billed.

SECTION III

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

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

FEDERAL ACQUISITION REGULATION

(48 CFR, CHAPTER 1) CLAUSES

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