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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CHANGE REQUEST 2231

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
7		Entire Chapter is New	

NEW MATERIAL - EFFECTIVE DATE: October 1, 2002
IMPLEMENTATION DATE: October 1, 2002

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

Please Note: These new manual instructions will be incorporated into the new Internet-only Office of Financial Management Manual once the manual is released in the near future. The CMS will not be placing these instructions into the old paper version of the MIM or MCM.

Medicare Financial Manual
Chapter 7 - Internal Control Requirements

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1 - Foreword - (Rev. 7, 08-30-02)

The purpose of this manual is to provide guidelines and policies to the Medicare Contractors to enable them to strengthen their internal control procedures. The past several years have confirmed a need for a structured internal control strategy and process for the Centers for Medicare & Medicaid Services (CMS). The General Accounting Office (GAO) and the Office of the Inspector General (OIG) have criticized CMS for its oversight of contractors, lack of knowledge of the adequacy of the operation of contractors' systems, and, in general, management of the Medicare program. Specifically, CMS had not provided a level of confidence for its internal control environment to assure that adequate systems of internal controls at its contractors were in place and operating efficiently. The Federal Managers Financial Integrity Act of 1982 (FMFIA) requires that internal control systems be established and maintained by each executive agency. It is CMS's belief that it needs to establish a more structured internal control process that is acceptable to outside oversight agencies to demonstrate compliance with FMFIA and serve as a tool in the oversight of Medicare Contractors.

The procedures and methods set forth in this manual have been devised to alleviate the problems and weaknesses for which the program has been cited.

10 - Introduction - (Rev. 7, 08-30-02)

10.1 - Authority - (Rev. 7, 08-30-02)

This section provides a brief description of the legislative requirements that drive the efforts of the Center for Medicare & Medicaid Services (CMS) to strengthen Medicare contractor internal controls. The FMFIA and CFOA establishes internal control requirements that must be met by CMS and impact the Medicare contractors. For CMS to meet the requirements of FMFIA and CFOA, Medicare contractors must demonstrate they comply with the respective FMFIA and CFOA guidelines.

10.1.1 Federal Managers' Financial Integrity Act of 1982 (FMFIA) – (Rev. 7, 08-30-02)

Congress passed the FMFIA in 1982 after a series of scandals and failed initiatives by the government to eliminate fraud, waste, and abuse. The act requires that internal accounting and administrative controls of each executive agency be established in accordance with the standards prescribed by the Comptroller General. Under FMFIA, the Office of Management and Budget (OMB) establishes guidelines for agencies to evaluate their systems of internal accounting and administrative control to determine such systems' compliance with the standards established by the Comptroller General.

Under FMFIA standards, agencies must provide reasonable assurance to the President and Congress on an annual basis that:

- Obligations and costs are in compliance with applicable law.

- Funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation.

- Revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accounts and reliable financial and statistical reports, and to maintain accountability over the assets.

10.1.2 - FMFIA and the CMS Medicare Contractor Contract – (Rev. 7, 08-30-02)

The CMS Medicare contract includes an article titled Federal Managers' Financial Integrity Act of 1982 (FMFIA). In this article the Medicare contractor agrees to cooperate with CMS in the development of procedures permitting CMS to comply with FMFIA and other related standards prescribed by the Comptroller General of the United States.

Under various provisions of the Social Security Act, Medicare contractors are to be evaluated by CMS on administrative service performance to ensure that contractors meet their contractual obligations. CMS may choose to evaluate a Medicare contractor's internal controls via various direct or indirect evaluation/oversight processes, e.g. Contractor Performance Evaluation (CPE) reviews, financial management reviews, SAS 70s to name a few review types.

The CPE evaluation criteria are categorized as "Fiscal Responsibility" and "Administrative Activities" and include expectations that Medicare contractors have effective internal controls. This expectation is for all aspects of a Medicare contractor's operation, as well as the degree to which it works with CMS in complying with the FMFIA.

To further sensitize Medicare contractors to the importance of FMFIA compliance, CMS has been requiring the Medicare contractors to annually provide assurance that it internal controls are in place and to identify and correct any areas of weakness in its operations. The vehicle used by the Medicare contractors to provide this assurance is referred to as the Certification Package for Internal Controls (CPIC). The CPIC includes a self-certification representation that the Medicare contractor's internal controls are in compliance with FMFIA, that the Medicare contractor recognizes the importance of internal controls, and has provided required documentation in the package per instructions.

10.1.3 - Chief Financial Officer's Act of 1990 (CFOA) - (Rev. 7, 08-30-02)

The CFOA was created in part to gain financial control of government operations. The CFOA establishes a leadership structure, provides for long range planning, requires audited financial statements, and strengthens accountability reporting. The aim of the CFOA is to improve financial management systems and information. The CFOA also requires the development and maintenance of agency financial management systems that comply with:

- Applicable accounting principles, standards, and requirements;

- Internal control standards; and

- Requirements of OMB, the Department of the Treasury, and others.

10.1.4 - OMB Circular A-123 - (Rev. 7, 08-30-02)

OMB Circular A-123, Management Accountability and Control, revised June 21, 1995, provides specific requirements for assessing and reporting on controls. The circular is issued under the authority of the FMFIA. It emphasizes that management controls should benefit rather than encumber management, and should make sense for each agency's operating structure and environment.

10.1.5 - GAO Standards for Internal Controls in the Federal Government - (Rev. 7, 08-30-02)

The FMFIA required the GAO to issue standards for internal control in government. GAO's Standards for Internal Controls in the Federal Government as updated in November 1999 provide the framework for establishing and maintaining internal controls and for identifying and addressing major performance and management challenges as well as areas of greatest risk of fraud, waste, abuse, and mismanagement. These are the internal control standards that CMS and its Medicare contractors are being held to.

10.2 - GAO Standards in the Federal Government - (Rev. 7, 08-30-02)

10.2.1 - Definition and Objectives - (Rev. 7, 08-30-02)

Internal controls ensure that operational objectives are carried out as planned in the most effective and efficient manner possible. CMS does not look upon internal controls as separate specialized systems, but are integral parts of each system that the Medicare contractor uses to accomplish the objectives of the Medicare program. In this, regard, internal controls are not just financial tools that safeguard assets, but are tools that are of vital importance to day-to-day programmatic and administrative operations as well.

Internal controls are an integral part of a Medicare contractor's management to provide reasonable assurance that the following objectives are being achieved:

- Effectiveness and efficiency of operations;

- Reliability of financial reporting; and

- Compliance with applicable laws and regulations

Internal control also serves as the first line of defense in safeguarding assets and preventing and detecting errors and fraud. In short, internal control, which is synonymous with management control, helps Medicare contractors achieve desired results through effective stewardship of resources.

10.2.2 - Fundamental Concepts - (Rev. 7, 08-30-02)

The three fundamental concepts provide the underlying framework for designing and applying the internal control standards.

A - A continuous built-in component of operations

Internal control includes measures and practices that are used to mitigate risks and exposures that could potentially prevent a Medicare contractor from achieving its goals and objectives. Internal control is not one event or circumstance, but a series of actions that permeate a Medicare contractor's activities. These actions are pervasive and are inherent in the way the Medicare contractor runs the Medicare contractor. Internal controls involve a Medicare contractor-wide commitment that defines and implements a continuous process of assessing, monitoring, and tracking activities and risks, through an integrated and effective communication mechanism.

B - Are effected by people

A Medicare contractor's management directs internal control, which is carried out by the people within that Medicare contractor. The Medicare contractor's commitment to establish strong internal control affects the Medicare contractor's practices. The Medicare contractor sets goals and policies, provides resources, and monitors and evaluates the performance of the Medicare contractor. The Medicare contractor's internal control environment is established by these policies and is controlled by available resources. Although internal control begins with this established environment, the employees make it work and must be adequately trained. It is the manner in which the entire Medicare contractor embraces the internal control that affects their accountability and operational results.

C - Provide reasonable assurance, not absolute assurance

Reasonable assurance indicates that an internal control system, no matter how well conceived and operated, can provide only reasonable, not absolute, assurance regarding achievement of an entity's objectives, and further indicates that the likelihood of achievement of these objectives is affected by limitations inherent in all internal control systems.

Examples of limitations are:

a. **Judgment -** the effectiveness of controls will be limited by decisions made by human judgment under pressures to conduct business based on information at hand;

b. **Breakdowns -** even well designed internal controls can break down. Employees sometimes misunderstand instructions or simply make mistakes. Errors may also result from new technology and the complexity of computerized information systems;

c. **Management Override -** high-level personnel may be able to override prescribed policies and procedures for personal gain or advantage. This

should not be confused with management intervention, which represents the Medicare contractor actions to depart from prescribed policies and procedures for legitimate purposes; and

d. **Collusion -** control systems can be circumvented by employee collusion. Individuals acting collectively can alter financial data or other management information in a manner that cannot be identified by control systems.

10.2.3 - Standards for Internal Control - (Rev. 7, 08-30-02)

Internal control consists of five interrelated standards. The GAO Standards for Internal Control in the Federal Government describes the five standards:

A. Control environment;

B. Risk assessment;

C. Control activities;

D. Information and communication; and

E. Monitoring.

Each of these internal control standards plays an important role in the overall control environment of a Medicare contractor. These standards define the minimum level of quality acceptable for internal control in government and provide the basis against which the internal control is to be evaluated.

While each internal control standard is an integral part of the management process and plays a specific role, it is the combination of these standards that establishes internal control at a Medicare contractor. The control environment provides the discipline and atmosphere in which the Medicare contractor conducts its activities and carries out its control responsibilities. It also serves as the foundation for the other standards. Within this environment, the Medicare contractor conducts risk assessments to assess potential affect of internal and external risks in achieving the Medicare contractor's objectives. Control activities are implemented to help ensure that the Medicare contractor directives are carried out as planned. Relevant information is captured and communicated in a timely and effective manner throughout the Medicare contractor on an ongoing basis. The Medicare contractor's operations are continuously monitored as an integral part of the Medicare contractor's performance evaluation.

10.2.3.1 - Control Environment - (Rev. 7, 08-30-02)

The Medicare contractor and employees should establish and maintain an environment throughout the Medicare contractor that sets a positive and supportive attitude toward internal control and conscientious management.

The control environment of a Medicare contractor sets the tone of a Medicare contractor, influencing the control consciousness of its people. It is the foundation for all other standards of internal control, providing discipline and structure. Control environment factors include the integrity, ethical values, and competence of the Medicare contractor's people; the Medicare contractor's philosophy and operating style; and the way the Medicare contractor assigns authority and responsibility and organizes and develops its human resources.

10.2.3.2 - Risk Assessment - (Rev. 7, 08-30-02)

Internal control should provide for an assessment of the risks the Medicare contractor faces from both external and internal sources.

Every Medicare contractor faces a variety of risks from external and internal sources that must be assessed. A precondition to risk assessment is establishment of control objectives, linked at different levels and internally consistent.

Risk assessment is the identification and analysis of relevant risks to the achievement of established objectives. When determining whether a particular control objective should be established, the risk of failure and the potential affect must be considered along with the cost of establishing the control.

10.2.3.3 - Control Activities - (Rev. 7, 08-30-02)

Internal control activities help ensure that the Medicare contractor's directives are carried out. The control activities should be effective and efficient in accomplishing the Medicare contractor's control objectives.

Control activities are the policies and procedures that help ensure the Medicare contractor directives are carried out. They help ensure that necessary actions are taken to address potential risks that may affect the Medicare contractor's objectives. Control activities occur throughout the Medicare contractor, at all levels and in all functions. They include a range of activities as diverse as approvals, authorizations, verifications, reconciliation, performance reviews, security of assets, and segregation of duties.

A. Examples of Control Activities:

- Top level reviews of actual performance;
- Reviews by the Medicare contractor at the functional or activity level;
- Management of human capital;
- Controls over information processing;
- Physical control over vulnerable assets;

- Establishment and review of performance measures and indicators;
- Segregation of duties;
- Proper execution of transactions and events;
- Accurate and timely recording of transactions and events;
- Access restrictions to and accountability for resources and records; and
- Appropriate documentation of transactions and internal control.

B. Control Activities Specific to Information Systems:

- General control: applies to all information systems - mainframe, minicomputer, network, and end-user environments.
- Application control: is designed to cover the processing of data within the application software.

10.2.3.4 - Information and Communication - (Rev. 7, 08-30-02)

Information should be recorded and communicated to the Medicare contractor and others within the entity who need it, and in a form and within a time frame that enables them to carry out their internal control and other responsibilities.

Pertinent information must be identified, captured, and communicated in a form and time frame that enables people to carry out their responsibilities. Information systems produce reports containing operational, financial, and compliance related information that make it possible to control the Medicare contractor. Information systems deal not only with internally generated data, but also information about external events, activities and conditions necessary for informed decision making and external reporting. Effective communication also must occur in a broader sense, flowing down, across, and up the organizational structure. All personnel must receive a clear message from top management that control responsibilities must be taken seriously. They must understand their own role in the internal control system, as well as how individual activities relate to the work of others. They must have a means of communicating significant information upstream. The Medicare contractor must also effectively communicate with external parties, such as customers, suppliers, state officials, and legislators.

10.2.3.5 - Monitoring - (Rev. 7, 08-30-02)

Internal control monitoring should assess the quality of performance over time and ensure that the findings of audits and other reviews are promptly resolved.

Internal control systems need to be monitored. Monitoring is a process that assesses the quality of the system's performance over time. Internal control should generally be designed to assure that ongoing monitoring occurs in the course of normal operations. This is accomplished through ongoing monitoring activities, separate evaluations or a combination of the two. Ongoing monitoring includes regular management and supervisory activities, and other action personnel take in performing their duties. The scope and frequency of separate evaluations will depend primarily on an assessment of risks and the effectiveness of ongoing monitoring procedures. Internal control deficiencies should be reported upstream, with serious matters reported to executive management.

20 - Medicare Contractor Internal Control Review Process – (Rev. 7, 08-30-02)

20.1 - Risk Assessment - (Rev. 7, 08-30-02)

Risk assessment identifies areas that should be reviewed to determine which components of a Medicare contractor's operation present the highest probability of waste, loss, or misappropriation. The risk assessment process is the identification, measurement, prioritization and mitigation of risks. This process is intended to provide the Medicare contractor with a:

- Direction for what areas should get priority attention from management due to the nature, sensitivity and importance of the area's operations;
- A preliminary judgment from managers about the adequacy of existing internal control policies and procedures to minimize or detect problems; and
- An early indication of where potential internal control weaknesses exist that should be corrected.

CMS requires Medicare contractors to perform an annual risk assessment, prior to conducting their reviews, to ensure that the most critical areas and areas of greatest risk are evaluated. Medicare contractors must submit a description of the risk assessment process to CMS as an attachment with the annual Certification Package for Internal Controls (CPIC) and maintain sufficient documentation to support the risk assessment process. The Medicare contractor is encouraged to exceed the risk assessment approach provided based on its unique operations. The risk assessment process should at a minimum include the following:

Step 1 - Segment Operations

Segment the Medicare contractor's operation into common operational areas of activity that can be evaluated. List the primary components of the unit with consideration to the business purpose, objectives, or goals of the audible unit. Limit the list to the primary activities designed to achieve the goals and objectives of the activity unit.

Step 2 - Prioritize Risk and Exposure Factors with a Matrix

Identify the primary risks and exposure factors that could jeopardize the achievement of the goals and objectives of the unit as well as the Medicare contractor's ability to achieve the objectives of reliable financial reporting, safeguarding of assets, and compliance with budget, laws, regulations and instructions. Risk and exposure factors can arise due to both internal and external circumstances. Document the definitions and methodology of the risk and exposure factors used in the risk assessment process.

Create a matrix listing on the left axis by operational areas of activity (see step 1 above). The top axis should list all the risk and exposure factors of concern and determine the weight each column should have. Some columns may weigh more than other columns. Develop a scoring methodology and provide a description and definitions of this methodology used for each risk or exposure factor. This methodology can use an absolute ranking or relative risk identification. Absolute ranking would assign predefined quantifiable measures such as dollars, volume, or some other factor in ranges that would equate to a ranking score such as high, medium or low. Relative risk ranking involves identifying the risk and exposure factors into natural clusters by definition and assigning values to these clusters.

Assign a score to each cell based on the methodology predetermined. Total the scores for each line item. The higher scores for each line item will prioritize the risk areas for consideration to be reviewed to support the CPIC.

20.2 - Internal Control Objectives - (Rev. 7, 08-30-02)

Internal control objectives are goals to reduce or eliminate risks. Every Medicare contractor establishes objectives that it wants to achieve and strategies for achieving them. Objectives may be set for an entity as a whole, or be targeted to specific activities within the entity. Generally, objectives fall into three categories:

1. Operations - relating to effective and efficient use of the Medicare contractor's resources.

2. Financial - relating to preparation of reliable financial statements.

3. Compliance - relating to the Medicare contractor's compliance with applicable laws and regulations.

An acceptable internal control system can be expected to provide reasonable assurance of achieving objectives relating to the reliability of operations, financial, and compliance. Achievement of those objectives depends on how activities within the Medicare contractor's control are performed.

In 20.2.1 below, CMS has provided a minimum set of generic control objectives for consideration by the Medicare contractor. These control objectives serve as a guide for consideration in your risk assessment process. The Medicare contractor is encouraged to add or customize the CMS control objective list to reflect their unique organizational structure. Rationale for deviating from the CMS control

objectives provided should be documented. The Medicare's contractor's control objectives should be compatible with the CMS control objectives.

For the respective operational areas selected for review in Step 2 of the Risk Assessment discussion, cross-reference the high risk operational areas to CMS's or the Medicare contractor's unique control objectives on a work sheet. Some control objectives will apply to more than one operational area selected for review. The control objectives identified in this step must be validated by documentation of the control activities (see 20.3 Control Activities below) utilized as well as testing (see 20.4 Testing Methods below) that supports the control objectives.

Reminder: Excessive control is costly and counterproductive. Too little control presents undue risk. There should be a conscientious effort made to achieve an appropriate balance.

20.2.1 - Medicare Control Objectives - (Rev. 7, 08-30-02)

Medicare Control Objectives

Control Number	Control Objective: Controls provide reasonable assurance that…
A	**Systems: Entity-Wide Security Program**
A.1	An entity-wide security program has been documented, approved, is monitored by management, and is in accordance with CMS guidelines.
A.2	Appropriately designated and authorized security personnel are in place.
A.3	Security related personnel policies are implemented and effective.
B	**Systems: Access Controls**
B.1	Information resources are classified (risk-ranked) according to their criticality/sensitivity and are periodically formally reviewed.
B.2	Access to computerized applications, systems software, and Medicare data is appropriately authorized, documented, and monitored.
B.3	Physical access to Medicare facilities and systems is appropriately authorized, documented, and access violations monitored and followed-up.
C	**Systems: Application Software Development and Change Control**
C.1	Medicare application and related systems software development and maintenance activities are authorized, documented, tested, and approved.
D	**Systems: Segregation of Duties**
D.1	Adequate segregation of duties exists between various functions within

	Medicare operations and is supported by appropriately authorized and documented policies.
D.2	Personnel activities are controlled using approved formal operating procedures and supervision/review of the use of these procedures.
E	**Systems: Service Continuity**
E.1	A regular assessment of the criticality and sensitivity of computerized operations and related supporting resources is performed.
E.2	A documented and approved comprehensive contingency plan has been developed, is periodically tested, and is updated as necessary.
F	**Claims Processing**
F.1	System capabilities and documentation are accessible in the Medicare claims processing system to track a claim from receipt to final resolution.
F.2	Data scheduled for processing is valid and errors are rejected.
F.3	Claims are processed accurately and in a timely manner in accordance with CMS guidelines.
F.4	Claims are reopened when necessary and in accordance with CMS guidelines.
F.5	Claim payments are properly calculated and duplicate claims are identified prior to payment.
F.6	Claims are properly aged from the actual receipt date to the actual date of payment in compliance with legislative mandates.
F.7	Personnel are trained to detect and deter fraudulent and abusive practices.
G	**Appeals**
G.1	Medicare Part A reconsiderations, Part A reviews, and Part A hearings are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines.
G.2	Medicare Part B reviews and hearings are processed based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines.
G.3	Administrative Law Judge (ALJ) cases are handled in compliance with legislatively mandated time frames.
G.4	Medicare appeals activities are carried out in order of priority as directed by CMS guidelines.

H	**Beneficiary/Provider Services**
H.1	Enroll providers in the Medicare Participation Program and issue provider numbers in accordance with CMS guidelines (Part B only).
H.2	Methodologies are established as approved by CMS to educate providers and beneficiaries in Medicare coverage, payment, and billing processes. Safeguards are in place to ensure Medicare information in provider bulletins is accurate and timely.
H.3	Personally identifiable health information, which is used and disclosed in accordance with the Privacy Act, is handled properly.
H.4	Safeguards are established in the Provider Enrollment Process to prevent sanctioned providers from receiving Medicare payment.
H.5	Beneficiary and provider written and walk-in inquiries are handled accurately, appropriately, and in a timely manner.
H.6	Telephone inquiries are answered timely, accurately, and appropriately.
I	**Fraud and Abuse - Benefit Integrity (BI)**
I.1	An independent BI unit that is responsible for detecting and deterring potential fraud should be developed and maintained.
I.2	Written procedures exist for BI unit personnel to use for the detection and review of potentially fraudulent situations.
I.3	Reactive and proactive techniques in the detection and development of potential fraud cases are used, especially in the area of data analysis.
I.4	Appropriate safeguard and administrative actions are taken when fraud is suspected including payment suspension, recovery of overpayments, provider education, referral to OIG, and denials of claims.
I.5	Management supports the networking and sharing of information on fraud cases across all program integrity areas, as well as the regional Medicare Fraud Information Specialist (MFIS) and law enforcement officials.
I.6	Written instructions exist detailing procedures for interaction between the BI unit and the following contractor units: Medical Review, Overpayment Recovery, Medicare Secondary Payer, Correspondence, Appeals, Provider Enrollment, Provider/Beneficiary Services and Audit/Reimbursement.
I.7	Procedures established for handling BI unit activities are compliant with the current Program Integrity Manual (PIM) instructions.
I.8	Procedures are in place and appropriate action taken by BI unit personnel to educate other contractor units within Medicare on detecting and referring

potential fraud situations. Procedures exist to ensure that other areas within the contractor's organization are alerted to procedural and programmatic weaknesses.

I.9 Information gathered by and furnished to the BI unit is maintained in a secure environment, kept confidential and the privacy of all parties protected.

I.10 Information compiled for direct and indirect reporting to CMS is clearly documented and can be traced to its original source.

I.11 Data residing within any automated Case Control system (e.g., Fraud Investigation Database (FID)) is entered timely and is complete and accurate. Staff is proficient in use of the system.

I.12 Inventory is properly controlled and monitored.

I.13 Necessary documentation regarding actions taken and final disposition is properly executed and maintained.

I.14 Requests for assistance from law enforcement agencies are responded to in a timely fashion.

I.15 Report requirements are met in an accurate and timely manner.

I.16 Notifications required by CMS are performed in a timely fashion and in accordance with CMS guidelines.

I.17 Provider amounts due are properly recorded and all subsequent transactions are properly accounted for and recorded.

I.18 Restricted and National Medicare Fraud Alerts are appropriately handled.

I.19 Regular communication takes place with the OIG on referred or pending cases and the contractor is taking appropriate administrative actions after consultation with OIG.

I.20 An established quality improvement program exists.

I.21 Contractors have incorporated fraud & abuse training into operations.

J **Medical Review (MR)**

J.1 Data analysis is performed to identify aberrant billing practices, potential areas of over utilization, and changes in patterns of care over time (trends) by providers and services that present financial risks through incorrect payments to the Medicare Program.

J.2 Data is used from CMS, the contractor’s internal databases, specialty data analysis contractors (e.g. Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) and Program Safeguard Contractor (PSC))

and other sources available to the contractors to identify targets for focused reviews.

J.3 Edits developed as a result of data analysis are effective in detecting inappropriate claims.

J.4 Medical Review is automated to the greatest extent possible.

J.5 Appropriate medical expertise is applied during the MR process.

J.6 Workload is accomplished in conformance with the current FY medical review strategy.

J.7 Current MR/Progressive Corrective Action (PCA), CMS issued instructions are used to verify that services on claims billed are covered and medically necessary.

J.8 The status of cases can be identified at any time and are closed timely.

J.9 The Medicare claims experience of all providers in the service area is monitored to acquire relevant statistical data on these claims and their specialty groups.

J.10 Providers are notified timely of any new or modified CMS guidelines and are educated on appropriate billing practices.

J.11 Provider contact resulting from the MR process is in compliance with the PCA and other Program Integrity Manual instructions relating to communication and education.

J.12 The Medicare contractor's management supports the internal networking and sharing of information on MR activities, potential fraud cases, audits, and MSP.

J.13 A quality improvement program ensures accuracy of Medical Review decisions.

K **Medicare Secondary Payer (MSP)**

K.1 MSP provisions are performed in accordance with current manual requirements.

K.2 Claims involving multiple payers are processed correctly; i.e., when Medicare is primary, claims are paid as primary.

K.3 Procedures and training materials are created and utilized to ensure consistency with all CMS applicable directives, regulations, etc., and compliance with the MSP provisions for the Internal Revenue Service/Social Security Administration/CMS Data Match Recoveries project should exist.

K.4 The contractor should document procedures that facilitate compliant

	treatment of MSP Data Match and Routine Recovery cases generated by the contractor when the third-party payer or the employer responds to any demand letter.
K.5	Clear audit trails for MSP recoveries (receivables) are maintained.
K.6	Timely reporting of required MSP reports exists.
K.7	Correspondence is issued to the appropriate parties in cases where other party primary liability is suspected.
K.8	Contractors should seek recovery of mistaken or conditional primary payments made in MSP situations in accordance with all CMS instructions.
K.9	Contractors are in compliance with CMS directives regarding debt referral as stated in the Debt Collection Improvement Act (DCIA).
L	**Administrative**
L.1	Employees must comply with applicable laws and regulations, a code of ethics, and conflict of interest standards. Education and training programs are in place to ensure that employees understand their responsibilities.
L.2	Procurements must be awarded and administered in accordance with the Medicare Agreement/Contract, CMS regulations, CMS general instructions, and the Federal Acquisition Regulation.
L.3	Incoming and outgoing mail must be properly handled in accordance with published time frames, security guidelines, and in the most cost effective and efficient manner.
L.4	Medicare management structure provides for efficient contract performance and is consistent with business practices.
L.5	Records must be retained according to guidelines established by CMS and other Federal agencies.
L.6	Business continuity plans must be in place, the plans must be tested periodically, and must cover relevant, distinguishable Medicare business units.
M	**Provider Audit and Reimbursement**
M.1	An internal quality control process must be established and maintained to ensure that audit work (full and limited audits and focused reviews) performed on providers' cost reports is accurate, meets CMS quality standards, and results in program payments to providers which are in accordance with Medicare law, regulations, and program instructions.
M.2	Information received by CMS or obtained by the contractor from other

sources to establish a new provider, process a change of ownership for an existing provider, terminate a provider, or process a change of intermediary are identified, recorded, and processed in a timely and accurate manner.

M.3 Interim, tentative, and PIP payments to Medicare providers are established, monitored, and adjusted, if necessary, in a timely and accurate manner in accordance with CMS general instructions and provider payment files are updated in a timely and accurate manner. Adjustments to interim payments must be made to insure that payments approximate final program liability within established ranges. Payment records are adequately protected.

M.4 Provider Cost Reports are properly submitted and accepted in accordance with CMS's general instructions, and cost report information is properly forwarded to the proper CMS system.

M.5 Desk review activity must be properly performed to obtain a fair and accurate review of the submitted cost report. Methods must be established and maintained to identify provider situations requiring a limited desk review, a complete desk review or a problem resolution.

M.6 Final settlement includes all adjustments to the cost report, and accurate and timely Notices of Program Reimbursement (NPR), including all related documentation, are issued to the providers.

M.7 Provider cost reports are reopened and settled in accordance with CMS program policy.

M.8 Provider exception requests are handled in accordance with all relevant regulations such as the TEFRA Target Limits.

M.9 Provider appeals (including both the Provider Reimbursement Review Board (PRRB) and Intermediary Appeals) are handled appropriately and all jurisdictional questions are addressed and all timeframes for submission are observed.

M.10 Information captured to update the Provider Statistical and Reimbursement Report (PSRR) is obtained, and related reports are distributed to providers and internally reconciled with paid claims files.

M.11 Inputs to mandated reports regarding provider audit, settlement, and reimbursement performance (STAR, CASR, etc.) are accurate and in compliance with program instructions.

N **Financial**

Transactions for Medicare accounts receivable, payables, expenses, and administrative costs must be recorded and reported timely and accurately, and financial reporting must be completed in accordance with CMS standards, Federal Acquisition Regulations (FAR), Financial Accounting

Standards Advisory Board, Cost Accounting Standards, and Generally Accepted Accounting Principles (GAAP). For the following control objectives, the review must focus on the following areas:

- Cost Report Settlement Process;
- Contractor Financial Reports:
    - Statement of Financial Position (CMS-H750A/B),
    - Status of Accounts Receivable (CMS-751A/B),
    - Status of Medicare Secondary Payer Accounts Receivable (CMS-M751A/B),
    - Status of Debt-Currently Not Collectible (CMS-C751A/B)
    - Status of Medicare Secondary Payer Debt-Currently Not Collectible (CMS-MEDICARE CONTRACTOR751A/B)
    - Reconcile to the Regional Office Status of Accounts Receivable (CMS-R751A/B) and Regional Office Status of Medicare Secondary Payer Accounts Receivable (CMS-RM751A/B),
    - Reconcile the accounts receivable balance and activity to the Provider Overpayment Reporting (POR) System and the Physician Supplier Overpayment Reporting (PSOR) system.
- Monthly Contractor Financial Report (CMS 1522) and Contractor Draws on Letter of Credit (CMS 1521),
- Reconciliation of Cash Balances and Cash Receipts.

N.1 Appropriately authorized personnel, in accordance with CMS' policies, approve recorded and processed transactions. In addition, Medicare contractor management and CMS policies are consistently applied.

N.2 Recorded and processed transactions are appropriately classified, maintained, summarized, and reconciled. In addition, all transactions must be adequately supported.

N.3 Adequate segregation of duties exists within the areas of disbursement and

collection (i.e., there should be separate authorization, record keeping, and custody).

N.4 Accounts receivable must exist, be valued, aged on an appropriate basis and correctly recorded in the books and records of the contractor.

N.5 The contractor must provide CMS with Contractor Financial Reports that are appropriately and adequately supported, documented, accumulated, completed, reviewed, formally approved, and presented timely to CMS.

N.6 Financial transactions received are valid and are appropriately supported, valued, recorded, and reported.

N.7 Banking information relevant to Medicare processing is accurately stated and conforms to the tripartite agreement.

N.8 Budget Performance Requirements are achieved per criteria established by CMS and exceptions are appropriately negotiated.

O Debt Collection

O.1 Documented procedures are used to collect provider debt timely and maintain appropriate audit trails of the collection activity that supports the amounts reported.

O.2 All appropriate entries to CMS' POR/PSOR and DCS systems are made timely and accurately, and reconciled among the relevant CMS systems.

O.3 The correct debt balance is reported and reconciled to all relevant CMS systems the contractor is responsible for maintaining and updating. Discrepancies are corrected and an audit trail is maintained.

O.4 All debts are appropriately aged, and related reports are reconciled to monitor CNC classification, status and follow up.

20.3 - Control Activities - (Rev. 7, 08-30-02)

Control activities are the policies, procedures, techniques, and mechanisms that enforce the Medicare contractor's directives and help ensure that actions are taken to address risks. The control activities should be effective and efficient in accomplishing the Medicare contractor's control objectives.

Control activities occur at all levels and functions of the Medicare contractor's operation. They include a wide range of diverse activities such as approval, authorizations, verifications, reconciliation, performance reviews, maintenance of security, and the creation and maintenance of related records that provide evidence of execution of these activities as well as appropriate documentation.

Effective and efficient control activities are expected to provide reasonable assurance of achieving control objectives relating to the reliability of the operation, financial reporting, and compliance with laws and regulations. Achievement of the control objectives depends on how activities within the Medicare contractor's control are performed.

Testing of the control activities provide a basis from which to verify if control objectives are being met and are effective.

20.4 - Testing Methods - (Rev. 7, 08-30-02)

While specific procedures on how to test and evaluate internal controls as well as the appropriate level of documentation to support the internal control review process is left to the discretion of a Medicare contractor's management, some general parameters are described:

Testing the policies and procedures involves ensuring that the documented policies and procedures are actually being used as designed and are effective to meet a control objective. Evaluating and testing the effectiveness of policies and procedures is important to determine if the major areas of risks have been properly mitigated and provide reasonable assurance that the control objective is meet.

Testing and evaluating the policies and procedures generally consist of a five-step:

Step 1: Select the policy or procedure to be tested

It is both impractical and unnecessary to test all policies and procedures. The policies and procedures to be tested are those that primarily contribute to the achievement of the control objectives. A policy or procedure may be eliminated from testing when it does not meet the control objective to be tested due to being poorly designed, unnecessary or duplicative, or not performed in a timely manner. However, if this justification is invoked, other policies and procedures must be tested to validate meeting the control objective. Another justification for testing elimination is due to the cost of testing the policy or procedure exceeds the value of the control objective to be tested.

If a policy or procedure is eliminated from testing, the reasoning must be documented.

Step 2: Select test methods

Once the policies and procedures to be tested are determined, test methods must be determined. A combination of tests may be used depending on risk or type of activity. The following methods may be used to test the policies and procedures:

1. Document Analysis: a test method used to determine if the policies and procedures are effective by reviewing existing records, completed forms, or other documentation.

2. Observations: a test method used to determine if the policies and procedures are working by watching the performance of that control objective. Observation is often used when the reviewer wants to test how the control objective works for an entire cycle for the function or activity. In this case, the observer watches the performance of all of the steps and observes all involved personnel. For example, a reviewer may observe what happens to a check from the time it is received to the time it is entered into the log and secured in the office safe. A reviewer records who took which steps, and which controls were used.

3. Interviews: a test method used to determine if the policy or procedure is working by eliciting information from the personnel who are responsible for the control objective. Interviews are used to supplement document analyses and/or observations. Interviews can provide valuable information about the operation of controls under many different situations.

Step 3: Determine how much testing is needed

The next sub-step is to determine the extent of the testing efforts. In most cases, it is unrealistic to observe each policy and procedure or to review 100 percent of all records. Instead, policies and procedures are tested by observing a selected number of controls performed or by reviewing a portion of the existing records. This selection process is called sampling. A representative sample provides confidence that the findings are not by chance by taking into account the factors of breadth and size.

1. Breadth: Breadth of the sample assures that the testing covers all bases and is a representative cross section of the universe being tested. This will provide confidence that the sample will lead to a conclusion about the situation as a whole.

2. Size: Size is the number of items sampled. The size must be large enough to allow a conclusion that the findings have not happened by chance and provide confidence in the conclusion. However the size of the sample must not be so large that testing becomes too costly. Selecting the size of the sample consider:

    a. Experience: Reduce the size of the sample when controls have operated satisfactorily in the past and no major changes in system/personnel have occurred.

    b. Margin of Error: Increase the size of the sample when only a small margin of error is acceptable.

c. Importance: Increase the size of the sample when an important resource is at stake.

d. Type: Increase the size of the sample when the control to be tested requires judgment calls. Decrease the size of the sample when the control is routine.

Step 4: Plan data collection

The sampling plan gives an idea of the who, what, when, and where aspect of the tests to be conducted. A data collection plan can be used to determine how the test results will be recorded. The accurate recording of test results is an extremely important part of the test documentation. Planning data collection prior to beginning the testing can be very helpful to ensure the information collected will provide conclusive data from which to evaluate the controls.

Step 5: Conduct the tests

The final step of testing and evaluating controls consists of actually effectuating the testing protocol and documenting the results.

At the conclusion of the testing, the results are analyzed and evaluated. Evaluating involves reviewing the information collected and making an overall judgment on the adequacy of the internal control system as a whole. Deficient areas are to be categorized into Reportable Conditions or Material Weaknesses (See 30.6, Definitions and Examples of Reportable Condition and Material Weakness).

20.5 - Documentation and Work Papers - (Rev. 7, 08-30-02)

The Medicare contractor must document through its work papers the process it employed to support its internal control certification. Working papers contain evidence accumulated throughout the review to support the work performed, the results of the review, including findings made, the judgment and/or conclusions of the reviewers. They are the records kept by the reviewer of the procedures applied, the tests performed, the information obtained, and the pertinent judgment and/or conclusions reached in the review process. Examples of working papers are review programs, analyses, memoranda, letters of confirmation and representation, abstracts of documents, and schedules or commentaries prepared or obtained by the reviewer. Working papers may be in the form of data stored on tapes, film, or other media.

General Content of Working papers - Working papers ordinarily include documentation showing that:

- The work has been adequately planned and supervised.

- The review evidence obtained, the reviewing procedures applied, and the testing performed have provided sufficient, competent evidential matter to support the reviewer’s judgments and/or conclusions.

Format of Working Papers - Working paper requirements ensure that the working papers follow certain standards. As a whole, a good set of working papers contain the following:

- The objectives, scope, methodology, and the results of the review.
- Proper support for findings, judgments and/or conclusions, and to document the nature and scope of the work conducted.
- Sufficient information so that supplementary oral explanations are not required.
- Adequate indexing and cross-referencing, and summaries and lead schedules, as appropriate.
- Date and signature by the preparer and reviewer.
- Evidence of supervisory review of the work.
- Proper heading, giving basic content of the working paper.

30 - Certification Package for Internal Controls (CPIC) - (Rev. 7, 08-30-02)
30.1 - Requirements - (Rev. 7, 08-30-02)

The Medicare contractor self-certification process supports the audit of CMS's financial statements by the Office of Inspector General (OIG) and the CMS Administrator's FMFIA assurance statement. The Medicare contractor self-certification process assures CMS that contractors are in compliance with the Federal Managers' Financial Integrity Act of 1982 (FMFIA) and Chief Financial Officer's (CFOA) Act of 1990 by incorporating internal control standards into operations.

Since 1995 CMS has partnered with its Fee-for-Service Medicare contractors to comply with the above Acts through a self-certification statement (from FY 1995 to FY 2000, called an Internal Control Certification Statement (ICCS) and since FY 2001, known as a Certification Package for Internal Controls (CPIC)). Through these self-certification statements, CMS has required each Medicare contractor to provide assurances that controls are in place and to identify and correct any areas of weakness in its operations. Medicare contractors are expected to evaluate the effectiveness of their operations against CMS's control objectives discussed above. The control objectives represent the minimum expectations for contractor performance in the area of internal controls.

Recent Statement of Auditing Standards Number 70 (SAS-70s) reviews and other financial management reviews continue to identify problems with documentation and substantiation of the financial data essential for CMS's preparation of its financial statements. All Medicare contractors are expected to maintain accurate

accounting records with supporting documentation, and to perform a reconciliation of all account balances.

The Medicare contractor is required to submit to CMS your CPIC, which includes a description of your risk assessment, certification statement, executive summary, and CPIC Reports of Material Weakness (es) and Reportable Condition(s), by October 15 each year.

CMS reminds the Medicare contractor of the importance of maintaining the appropriate and necessary documents to support any assertions and conclusions made during the self-assessment process. In your work papers, the Medicare contractor is required to document the respective policies and procedures for each control objective reviewed. These policies and procedures should be in writing, be updated to reflect any changes in operations, and be operating effectively and efficiently within your Medicare contractor.

Understand that the supporting documentation and rationale for your certification statement, whether prepared internally or by an external organization, must be available for review and copying by CMS and its authorized representatives.

Every Medicare contractor faces a variety of risks from external and internal sources that must be assessed. Risk assessment is the identification and analysis of relevant risks to the achievement of established control objectives. The Medicare contractor is required to perform a yearly risk assessment, prior to conducting your reviews, to ensure that the most critical areas are evaluated. CMS have included, in 20.2.1, a list of control objectives. These control objectives are intended to be a minimum set of control objectives for consideration and are to serve as a guide during your risk assessment process. CMS expect the Medicare contractor will add to this list as they conduct their risk assessment.

When performing your yearly risk assessment, the Medicare contractor is to consider all results from internal (management) and external reviews including GAO, OIG, CFO audit, Contractor Performance Evaluation (CPE), and results of your own and/or CMS-sponsored SAS-70 reviews. Any of these efforts could impact your risk assessment and preparation of your certification statement. Your risk assessment process must provide sufficient documentation to fully explain the reasoning behind and the planned testing methodology for each selected area. A description of your risk assessment process (which explains the steps and areas considered) must be included in your CPIC.

CMS considers financial management to be a critical risk area. Therefore, CMS requires that the Medicare contractor include the financial management control objectives in your CPIC. (See sections K, M, N, and O in 20.2.1) If the Medicare contractor believes, based upon their risk assessment that they should not review these areas, the Medicare contractor must document this in your CPIC.

30.2 - Certification Statement - (Rev. 7, 08-30-02)

The Medicare contractor is required to provide a certification statement to CMS pertaining to its internal controls. Listed below is a generic certification statement.

This statement must be included as part of your CPIC. The statement is to be signed jointly by your Medicare Chief Financial Officer and Vice President for Medicare and is due by October 15 each year.

The Medicare contractor's certification statement should follow this outline:

Ms. A. Michelle Snyder
Chief Financial Officer
Office of Financial Management
Attn: Internal Controls Team
Centers for Medicare & Medicaid Services
7500 Security Boulevard, C3-13-08
Baltimore, MD 21244-1850

Dear Ms. Snyder:

As (Medicare Chief Financial Officer, Vice President for Medicare, or appropriate equivalent) of (contractor name), I am writing to provide certification of reasonable assurance that (contractor name) internal controls are in compliance with the Federal Managers' Financial Integrity Act (FMFIA) and Chief Financial Officers (CFOA) Act by incorporating internal control standards into my operations.

I am cognizant of the importance of internal controls. I have taken the necessary actions to assure that an evaluation of the system of internal controls and the inherent risks have been conducted and documented in a conscientious and thorough manner. Accordingly, I have included an assessment and testing of the programmatic, administrative, and financial controls for the Medicare program operations.

In the enclosures to this letter, I have provided an executive summary that identifies: A) The contractor identification numbers; B) The geographical locations for which the certification applies; C) The functional areas selected for review; D) The time period during which the reviews were conducted; E) A brief summary of the review results (including a time estimate for when the deficiency will be corrected); F) The name and title of the person(s) who conducted the review; G) The location and custodian of the working papers for the review; and H) The name, telephone number, and email address of a contact person. Material weaknesses have been reported to CMS central office and the appropriate regional office. The respective Corrective Action Plans have been forwarded to your office. I have also included a description of our risk assessment analysis and Certification Package for Internal Controls Report of Material Weakness(es) and Reportable Condition(s). This letter and its attachments summarize the results of our review.

I also understand that officials from the Centers for Medicare & Medicaid Services, Office of Inspector General, General Accounting Office, or any other appropriate Government agency have authority to request and review the work papers from our evaluation.

For layout purposes only

Sincerely,

(Medicare Chief Financial Officer Signature)

(Vice President for Medicare Signature)

30.3 - Executive Summary - (Rev. 7, 08-30-02)

An executive summary must be included in the Medicare contractor's CPIC. This summary must provide, at a minimum:

A. The contractor identification numbers;

B. Geographical locations for which the certification applies;

C. The functional areas selected for review;

D. The time period during which the reviews were conducted;

E. A brief summary of the review results, time estimate for when any deficiency will be corrected;

F. The name and title of the person(s) who conducted the review;

G. The location and custodian of the working papers; and

H. The name, telephone number, and E-mail address of a contact person who can explain the risk assessment process, the certification review, the results, and the status of any corrective action plans.

Within this report, the Medicare contractor is asked to identify all reportable conditions and material weaknesses noted for the reported fiscal year to include those that have been corrected. Keep in mind that while the Medicare contractor is required to document, track, and correct problems identified as reportable conditions, no corrective action plan (CAP) is required. **With a material weakness, however, the Medicare contractor is required to provide written notification, including a CAP, to your regional office within 30 calendar days of identifying the problem.** Within that same time frame the Medicare contractor is required to send an electronic copy to the CMS central office, via E-

mail, to CAPS@cms.hhs.gov and provide a hard copy of the CAP to the Office of Financial Management at the address listed below.

After CMS has completed its review and approval process, the Medicare contractor is required to include all CPIC material weakness CAPs on the Universal CAP report that may already include CAPs from the SAS-70, CFO audit, Accounts Receivable review, or other financial management reviews. The Universal CAP report will be submitted electronically to CAPS@cms.hhs.gov as well as to the appropriate regional office.

Note that the Medicare contractor must reference from 20.2.1 the control number that corresponds to the control objective impacted by the material weakness or reportable condition when preparing the CPIC reports. Each finding should be categorized as either a material weakness or a reportable condition. These terms are defined in 30.6 below and examples of each have also been provided. In your CPIC Report of Material Weaknesses the Medicare contractor must also identify the status of the CAP for each material weakness. An electronic version of the CPIC Reports of Material Weaknesses and Reportable Conditions must be sent to CMS at internalcontrols@cms.hhs.gov in Microsoft Excel 97 or other compatible software program.

The CPIC represents an annual summary of your internal control environment for the current fiscal year as certified by the Medicare contractor. All SAS-70 exceptions identified during the fiscal year must be reflected in your CPIC report. Each exception should be classified as a material weakness and therefore a CAP must be submitted. However, there is no need to write duplicate CAPs for SAS-70 exception(s) already identified in your Universal CAP report.

The Medicare contractor's CPIC package should be sent to the Office of Financial Management at the address listed below:

Ms. A. Michelle Snyder
Chief Financial Officer
Office of Financial Management
Attn: Internal Controls Team
Centers for Medicare & Medicaid Services
7500 Security Boulevard, C3-13-08
Baltimore, MD 21244-1850

A copy must also be forwarded to your regional office, attention: Associated Regional Administrator, Division of Financial Management. Also, an electronic copy of the documents included in your CPIC package (in a format compatible with Microsoft Office 97) must be sent to internalcontrols@cms.hhs.gov.

30.4 - CPIC- Report of Material Weaknesses - (Rev. 7, 08-30-02)

The CPIC Report of Material Weaknesses is an annual summary of the material weaknesses identified during the fiscal year. Material Weaknesses opened and closed within the reporting period are to be included in the report.

The CPIC Report of Material Weaknesses should be prepared as a spreadsheet and include the following columns of information:

1. CMS Finding Number (to be assigned by preparer of the CPIC).

2. The original source of the finding, the control objectives numbers impacted (from 20.2.1).

3. A summary of the material weakness.

4. The corrective action plan (CAP).

5. Target completion date for the CAP.

6. Actual completion date for the CAP (if completed).

7. Dollar impact on the Medicare Trust Fund.

CMS Finding Numbers are to be assigned to each material weakness by the preparer of the CPIC prior to submission to CMS. These unique identifiers should be assigned using the following instructions. Each section of digits should be separated by a dash.

A. The first three or four digits are letters which identify the name of the contractor. Each contractor is assigned a unique set of letters in Table 2 listed below.

B. The second two digits are the last two numbers of the year of the review.

C. The next one or two digits are letters to identify the type of review. Choose only one of the five in the following list: AR-Accounts Receivable review, C-CPIC, E-CFO EDP review, F-CFOA Financial review, and S-SAS-70.

D. The last two digits are two numbers assigned to each individual finding (beginning with 01, 02, 03, etc.).

For example, for material weaknesses reported in a Certification Package for Internal Controls (CPIC) for FY 2003, the CMS Finding Numbers would be ASF-03-C-01, ASF-03-C-02, ASF-03-C-03.

30.4.1 - Contractor Finding Numbers - (Rev. 7, 08-30-02)

Contractor Finding Numbers

AdminaStar Federal Inc.	ASF
Anthem Health Plans of New Hampshire, Inc. (d.b.a. Anthem Blue Cross and Blue Shield of New Hampshire)	ANT
Arkansas Blue Cross and Blue Shield	ARK
Anthem Health Plan of Maine (d.b.a.Associated Hospital Service of Maine)	AHS
Blue Cross and Blue Shield of Alabama (Cahaba Government Benefit Administrators)	ALA
Blue Cross and Blue Shield of Arizona, Inc.	ARZ
Blue Cross and Blue Shield of Georgia, Inc.	GEO
Blue Cross and Blue Shield of Kansas, Inc.	KAN
Blue Cross and Blue Shield of Mississippi (d.b.a. Trispan)	TRI
Blue Cross and Blue Shield of Montana, Inc.	MNT
Blue Cross and Blue Shield of Nebraska	NEB
Blue Cross and Blue Shield of Rhode Island	RHI
Blue Cross and Blue Shield of South Carolina (d.b.a. Palmetto Government Benefits Administrators)	PGBA
Blue Cross and Blue Shield of Tennessee (d.b.a. Riverbend Government Benefits Administrators)	RGBA
Blue Cross and Blue Shield of Western New York, Inc. (Healthnow New York, Inc.)	HLN
Blue Cross and Blue Shield of Western New York, Inc. (Healthnow-DMERC)	HLND

Blue Cross and Blue Shield of Wyoming	WYG
Blue Cross and Blue Shield United of Wisconsin (d.b.a. United Government Services, LLC)	UGS
Care First of Maryland, Inc.	CFM
Connecticut General Life Insurance Company (a CIGNA Company)	CIG
Cooperativa de Seguros de Vida de Puerto Rico	COP
Empire Healthchoice, Inc. (d.b.a. Empire Medicare Services)	EMP
First Coast Service Options, Inc.	FCSO
Group Health Incorporated	GHI
Group Health Service of Oklahoma, Inc. (d.b.a. Blue Cross and Blue Shield of Oklahoma)	GHO
Highmark Inc. (d.b.a. HGSAdministrators)	HGSA
Highmark Inc. (d.b.a. Veritus Medicare Services)	VRT
Mutual of Omaha Insurance Company	MUT
National Heritage Insurance Company	NHIC
Nationwide Mutual Insurance Company	NAT
Noridian Mutual Insurance Company	NOR
Premera Blue Cross	PRM
Regence Blue Cross Blue Shield of Oregon (Medicare Northwest)	MNW
Regence Blue Cross Blue Shield of Utah	UTAH

TrailBlazer Health Enterprises, LLC	THE
Triple-S, Inc.	SSS
Wisconsin Physicians Service Insurance Corporation	WPS

30.5 - CPIC- Report of Reportable Conditions - (Rev. 7, 08-30-02)

The CPIC Report of Reportable Conditions is an annual summary of the reportable conditions identified during the fiscal year. Reportable Conditions opened and closed within the reporting period are to be included in the report.

The CPIC Report of Reportable Conditions must be prepared as a spreadsheet and include the following columns of information:

1. The original source of the finding.
2. The control objective numbers impacted (from 30.4).
3. A summary of the reportable condition.
4. Dollar impact on Medicare Trust Fund.

This report should be prepared in Microsoft Excel 97 or a compatible spreadsheet program and submitted to internalcontrols@cms.hhs.gov as a part of your CPIC.

30.6 - Definitions and Examples of Reportable Conditions and Material Weaknesses - (Rev. 7, 08-30-02)

Contractors are expected to identify a Reportable Condition and/or Material Weakness in their Certification Package for Internal Controls (CPIC). These terms are defined as follows:

A **REPORTABLE CONDITION** exists when your internal controls are adequate in design and operation and reasonable assurance can be provided that the intent of the control objective is met, but deficiencies were found during the review that requires correction. It is necessary for contractors to track and correct the problem, but no CAP need be submitted to CMS. The Medicare contractor must, however, inform CMS when the condition was observed and corrected (or the status if not corrected), and include information on any dollar impact on the Medicare Trust Funds.

EXAMPLES:

Access controls are in place within the data centers; however, during the review it was found that particular employee passwords were openly displayed. (Control

Objective B.3 - Physical access to Medicare facilities and systems is appropriately authorized, documented, and access violations monitored and followed-up.)

While controls are in place, isolated incidents occurred where some supporting documentation for the CMS 1522 report could not be located. (Control Objective N.5 -The contractor must provide CMS with contractor financial reports that are appropriately and adequately supported, documented, accumulated, completed, reviewed, formally approved and presented timely to CMS.)

A **MATERIAL WEAKNESS** exists when the contractor fails to meet a control objective. This may be due to a significant deficiency in the design and/or operation of internal control policies and procedures. Because of these shortfalls in internal controls, the contractor cannot provide reasonable assurance that the intent of the control objective is being met. Contractors should, however, inform CMS when the condition was observed and corrected (or the status if not corrected), and include information on any dollar impact on the Medicare Trust Funds.

With a material weakness, the Medicare contractor is required to provide a CAP, to your regional office within 30 calendar days of identifying the problem. Within that same time frame the Medicare contractor is required to send an electronic copy to internalcontrols@cms.hhs.gov and provide a hard copy of the CAP to the Office of Financial Management at the address listed in 30.3.

EXAMPLES:

No controls are in place for access to data. Employees within certain data centers were found to share the same password. (Control Objective B.3 - Physical access to Medicare facilities and systems is appropriately authorized, documented, and access violations monitored and followed-up.)

Formal processes for developing supporting documentation for value of outstanding Medicare payment checks for inclusion in CMS 1522 report were not implemented and related documentation could not be located to support estimates used for the period reviewed. (Control Objective N.5 - The contractor must provide CMS with contractor financial reports that are appropriately and adequately supported, documented, accumulated, completed, reviewed, formally approved and presented timely to CMS.)