CMS Manual System

Pub 100-06 Medicare Financial Management

Transmittal 84

Department of Health & Human Services (DHHS)

Centers for Medicare & Medicaid Services (CMS)

Date: NOVEMBER 16, 2005

Change Request 4060

SUBJECT: Revised Instructions on Contractor Procedures for Provider Audit, and Clarification of CET Requirements for Medicare Auditors.

NOTE: Transmittal 83, dated November 04, 2005 is rescinded and replaced with Transmittal 84, dated November 16, 2005. The implementation date on the manual instruction was incorrectly stated as 12-05-06. The correct implementation date is 12-05-05. All other information remains the same.

I. SUMMARY OF CHANGES: This revision incorporates changes to instructions aimed at improving Medicare contractors operation in the areas of audit and settlement. Also to clarify CET requirements for Medicare auditors.

NEW/REVISED MATERIAL
EFFECTIVE DATE: December 5, 2005
IMPLEMENTATION DATE: December 5, 2005

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R = REVISED, N = NEW, D = DELETED – *Only One Per Row.*

R/N/D	Chapter / Section / SubSection / Title
R	8/10/10.4/Submission of Cost Report Data to CMS
R	8/40/40.2/ Audit Priority Consideration
R	8/60/60.10/ Pre-Exit Conference
R	8/60/60.11/ Finalization of Audit Adjustments
R	8/80/ Standards for Performing Medicare Audits
R	8/80/80.01/ Qualifications
R	8/80/80.03/ Due Professional Care

R	8/80/80.04/ Internal Quality Control
R	8/90/ Final Settlement of the Cost Report
R	8/120/120.4/ Timing and Completion of Home Office Audits
N	8/120/120.8/ Acceptance of Home Office Cost Statements

III. FUNDING:

No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.

IV. ATTACHMENTS:

Business Requirements

Manual Instruction

**Unless otherwise specified, the effective date is the date of service.*

Attachment - Business Requirements

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I. GENERAL INFORMATION

A. Background: This revision incorporates changes to the instruction aimed at improving Medicare contractors operation in the areas of audit and cost report settlement.

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

II. BUSINESS REQUIREMENTS

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

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4060.1	The contractor shall submit an extract of CMS Form 2540-96, Skilled Nursing Facility Cost Report, for cost reporting ending on or after June 30, 1996 in accordance with the Health Care Cost Report Information System specification to CMS within 210 days of the cost report period ending date or 60 days after receipt of the cost report (Section 10.4).	X								
4060.2	The contractor shall submit an extract of CMS Form 1728-94, Home Health Agency Cost Report, for cost reporting ending on or after December 31, 1994, in accordance with the Health Care Cost Report Information System specification to CMS within 210 days of the	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	cost report period ending date or 60 days after receipt of the cost report (Section 10.4).									
4060.3	The contractor shall recognize that the audit of ESRD to be performed for the three year cycle can be either a field audit or desk audit (Section 40.2).	X								
4060.4	The contractor shall establish an exit conference within 8 weeks from the end of the 4 weeks given to the provider to submit additional documentations at the pre-exit (Section 60.10).	X								
4060.5	The contractor shall finalize audit adjustments within 12 weeks from the pre-exit date, and this includes the 2 weeks given to the providers to review any new adjustments (Section 60.11).	X								
4060.6	The contractor shall meet 24 hours of government related CET requirement in each 2 year period for auditors who are not involved in planning, directing, or reporting on the audit or attestation engagements, and who charges less than 20 percent of their time to audit and attestation conducted under Generally Accepted Auditing Standards (Section 80.1).	X								
4060.7	The contractor shall settle amended cost report within the greater of 5 months from the acceptance of the amended cost report or time left of the 12 months from the acceptance of the "initial" filed cost report if the cost report is not scheduled for an audit (Section 90).	X								
4060.8	The contractor shall finalize home office cost statements received on or after October 2005 within 12 months from the date of acceptance if the cost statement is not going to be audited (Section 120.4).	X								

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
4060.9	The contractor shall determine the acceptability of home office cost statements within 30 days of receipt of a home office cost statements (Section 120.8).	X								

III. PROVIDER EDUCATION

Requirement Number	Requirements	Responsibility ("X" indicates the columns that apply)								
		FI	RHHI	Carrier	DMERC	Shared System Maintainers				Other
						FISS	MCS	VMS	CWF	
	None.									

IV. SUPPORTING INFORMATION AND POSSIBLE DESIGN CONSIDERATIONS

A. Other Instructions: N/A

X-Ref Requirement #	Instructions

B. Design Considerations: N/A

X-Ref Requirement #	Recommendation for Medicare System Requirements

C. Interfaces: N/A

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

E. Dependencies: N/A

F. Testing Considerations: N/A

V. SCHEDULE, CONTACTS, AND FUNDING

Effective Date*: December 5, 2005 **Implementation Date:** December 5, 2005 **Pre-Implementation Contact(s):** Owen Osaghae (410) 786-7550 **Post-Implementation Contact(s):** William T. Grieves (410) 786-3373	**No additional funding will be provided by CMS; contractor activities are to be carried out within their FY 2006 operating budgets.**

***Unless otherwise specified, the effective date is the date of service.**

Medicare Financial Management Manual

Chapter 8 – Contractor Procedures for Provider Audits

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10.4 – Submission of Cost Report Data to CMS

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

You are required to submit an extract of the following Medicare cost reports to CMS in accordance with the Healthcare Cost Report Information System (HCRIS) specifications within 210 days of the cost reporting period ending date or 60 days after receipt of the cost report, whichever is later.

- CMS Form 2552-96, Hospital Cost Report, for cost reporting periods ending on or after September 30, 1996
- CMS Form 2540-96, Skilled Nursing Facility Cost Report, for cost reporting periods ending on or after *June* 30, 1996
- CMS Form 1728-94, Home Health Agency Cost Report, for cost reporting periods ending on or after *December 31*, 1994
- CMS Form 265-94, Renal Dialysis Cost Report, for cost reporting periods ending on or after December 31, 1994
- CMS Form 1984-99, Hospice Cost Report, for cost reporting periods beginning on or after April 1, 1999

This submission must pass all level one electronic cost report edits (see §10.3 of this chapter) and all HCRIS reject edits.

If the cost report is deemed to be "Low Medicare utilization" or "No Medicare utilization", do not submit a HCRIS extract of the "as submitted" cost report.

40.2 – Audit Priority Considerations

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

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

A – Significance of Total Medicare Program Payments

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

- Bad debts.

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

B – Types of Providers

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

- New providers.
- Providers reimbursed on a cost basis (e.g., critical access hospitals, cancer hospitals).
- End Stage Renal Disease Facilities need to be audited in accordance with the Balanced Budget Act requirements. *The audit of End Stage Renal Dialysis Facilities to be performed for the three year cycle can be either a field audit or a desk audit*
- Providers receiving significant non-PPS payments.
- Providers that were not audited recently.

C – Conditions and Occurrences at the Provider

- Change of ownership, termination, or change of provider type (e.g., critical access hospitals).
- Cost report filed late without a satisfactory explanation.

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

60.10 – Pre-Exit Conference

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

Conduct a pre-exit conference on the last day that the audit team is conducting the fieldwork. Give the provider a copy of all the tentative audit adjustments and working papers (where requested by the provider) including those being proposed due to lack of documentation and discuss all the tentative adjustments that the provider wishes to go over. Also, give the provider a written list of any outstanding documentation that you requested but have not received to date. Inform the provider to furnish your audit staff with the additional documentation within 4 weeks. Establish an exit conference date that will allow up to 8 weeks (or longer if you can document extenuating circumstances) *from the end of the 4 week period given to the provider to provide additional documentation.*

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

60.11 – Finalization of Audit Adjustments

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

Use the time period between the pre-exit conference and exit conference to review any additional documentation submitted by the provider in response to your request at the pre-exit conference or in support of the proposed audit adjustments that the provider did not agree with. CMS encourages continuing dialogue during this period between you and the provider for issues where agreement was not reached at the pre-exit conference. However, it is not necessary to consider any documentation that is received after the timetable provided at the pre-exit conference unless prior arrangements with the provider have been made.

While you should not refuse to accept documentation submitted after the established timeframes, you do not need to consider it in the initial NPR issuance. If a reopening is later granted (see §100ff of this chapter) or a timely appeal is made, the late documentation may be considered at that time.

At the conclusion of your review of the provider's documentation, prepare an audit adjustment report (see Exhibit VI in §170 of this chapter) and clearly identify all new or modified adjustments that the provider did not see previously by indicating the date of the change. Send this audit adjustment report to the provider with a request to notify you in writing, within 2 weeks, of any concerns with the new or modified adjustments. Also, inform the provider in writing that the audit adjustments will become final after you make any necessary modification based on those written concerns and documentation supporting them. Therefore, any documentation submitted later (e.g., at the exit

conference) will not be considered for the purpose of issuing the Notice of Amount of Program Reimbursement (NPR).

> Unless you can document extenuating circumstances, you have up to *12* weeks from the *pre-exit conference for the finalization of the audit adjustments.* This period *include the 4 weeks given to the provider to submit additional documentation and* the "2 weeks" that you must give the provider to review and comment on any audit adjustments not presented at the time of the pre-exit conference.

80 – Standards for Performing Medicare Audits

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

In performing a Medicare audit, comply with the standards outlined in *this chapter. Although not exact these standards reflect* Chapter 3 of the Government Auditing Standards (GAS) entitled "General Standards". The American Institute of Certified Public Accountants (AICPA) Statements on auditing standards have been adopted and incorporated as GAS requirements.

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

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

80.1 – Qualifications

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

The first general standard for government auditing is:

"The staff assigned to conduct the audit should collectively possess adequate professional proficiency for the tasks required."

Ensure that the Medicare audit is conducted by staff that collectively has the knowledge and skills necessary for the audit. These qualifications apply to the knowledge and skills of the contractor's organization as a whole, and not necessarily to every individual auditor.

A – Continuing Education and Training (CET)

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

The following represent the continuing education responsibilities of an audit organization and also reflect additional guidance from CMS to help the contractor.

B – Education Required

All persons responsible for planning, directing, conducting, reviewing, or reporting on government audits must receive at least 80 hours of continuing education and training (CET) every two years. For example, auditors who first start conducting audits on January 1, 2002, must complete the CET requirements as follows:

- The first 80 hours must be completed by December 31, 2003. Any excess over the 80-hour requirement does not carry forward to the next two-year cycle.
- After CET requirements for the first two-year period (i.e., January 1, 2002, to December 31, 2003) have been satisfied, a rolling count is permissible for measuring compliance with the requirements. Under a rolling count, compliance with the CET requirements is measured annually using the two most recent years.
- At least 20 hours must be completed in each year of the two-year cycle.
- At least 24 of the 80 hours must be in subjects directly related to government environment and to government auditing. Since the contractor is operating in a specific or unique environment, i.e., Medicare, it shall schedule the 24 hours of training, noted above, in subjects related to the government environment and to the Medicare auditing process.
- Appropriate courses on Medicare and other health care related issues include, but are not limited to, GAS, Medicare policy development (how it affects audits), preparation and review of Medicare audit working papers, current Medicare audit and payment issues, and the AICPA Audit and Accounting Guide: Providers of Health Care Services.

For purposes of the 80-hour and the 24-hour requirements, CMS interprets the term "conducting" and the phrase "conducting substantial portions of the field work" as referring to those individuals who perform substantial portions of the tests and procedures necessary to accomplish the audit objectives. An individual is considered to be responsible for "conducting substantial portions of the field work," for purposes of the CET requirements, when the following conditions are met:

- On a given audit, the individual performs 20 percent or more of the total field work; or
- In a given year, the individual's chargeable time to government audits is 20 percent or more of the individual's total chargeable time.

Staffs who are only involved in performing audit work but not involved in planning, directing, or reporting on the audit or attestation engagement and who charges less than 20 percent of their time to the, desk review, audit and attestation engagement are

required to take 24 hours of government related CET in each 2 year period. However, they are not required to comply with the 80-hour CET requirement.

Auditors who have been employed by the audit organization for less than one year of a given two-year period are not required to complete a minimum number of CET hours. However, entry-level auditors with less than one year with the audit organization must receive appropriate training during their first year with the audit organization. Auditors employed by the audit organization for one year, but less than two years, in a given two-year period, must complete a minimum of 20 hours of CET in the full calendar year. All auditors to whom the CET requirements for 80 hours and 24 hours apply have two years to meet the requirements.

Terminated employees must have been trained in accordance with the contractor's plan of training, at least until a formal notice of termination is received or issued.

Auditors who have not completed the required number of CET hours for any two-year period for a legitimate reason will have the two months immediately following the two-year period to make up the deficiency. Auditors must make up any deficiency in the 24-hour requirement first. The contractor shall not count any CET hours completed towards a deficiency toward either the 20-hour requirement in the year in which they are taken, or the 80-hour and the 24-hour requirements for the two-year period in which they are taken.

C – Employees Covered Under the CET Requirement

Any auditor who is responsible for planning, directing, conducting, reviewing, or reporting on government audits is subject to the CET requirements. Also, anyone whose decisions affect the outcome of government audits is covered by CET requirements. Since the contractor may use various types of employees in the audit process, the following is CMS's interpretation of the applicability of CET requirements to certain types of employees:

- Junior Auditors – CET requirements extend to junior auditors who perform portions of the audit. "Conducting" is not limited to auditors in a supervisory or management role.

- Contract Auditors –When the contractor contracts with CPA firms for entire audits, or to provide audit staff to work under its supervision, they are subject to the same requirements as the contractor. The contractor shall require compliance with the CET requirements as a specific condition of the audit subcontract. It shall obtain written assurance that each person meets CET requirements prior to the start of each audit.

- Temporary Auditing Staff – A temporary auditor who is hired for a very limited timeframe, not to exceed one quarter at a time or in one year, under the contractor's direct supervision, is not subject to CET requirements.

- Crossover Staff – Staff members used in multiple functions must meet the CET requirements when their decisions could affect the outcome of an audit. For CET purposes employees who are transferred to the Medicare audit department are considered new hires, as are employees who are promoted to a professional staff level.

- External Consultants and Internal Consultants and Specialists – External consultants and internal consultants and specialists must be qualified and must maintain their professional proficiency in their area of expertise and specialization, but they are not required to meet CET requirements. For example, attorneys the contractor employs, who work in the provider appeals area, are not subject to the CET requirements, but they must maintain their professional proficiency.

- Clerical and Paraprofessional Staff – Clerical and paraprofessional staff, including student interns, are not subject to the CET requirements.

Review all position descriptions to ensure that they accurately reflect the employees' duties and responsibilities. If you have concerns or questions on certain position descriptions, submit your questions to your RO for a determination. These position descriptions will be reviewed by CMS and the Office of the Inspector General (OIG) to determine the need for compliance with the CET requirements.

D – Contractor Responsibility

Establish and implement a program to ensure that the auditors meet the CET requirements. You must:

- Prepare a general plan for training. Review and revise the plan, as appropriate, and allocate resources to ensure that all staff subject to CET requirements receive training; and

- Implement the CET program to ensure that for every two-year period the 80-hour and 24-hour requirements are met, and that at least 20 CET hours are completed in each year of the two-year period.

- Retain course information for your employees receiving CET credit for contractor-sponsored courses. Maintain records for a five-year period from the completion of the two-year period. Maintain a record for each employee which reflects:
  - Record of participation;
  - Course agenda;

  - Course date(s);
  - Location at which the course was given;
  - Name(s) of instructor(s) and related training, education, and experience;
  - Number of CET credit hours; and
  - Copy of course material presented.
- Retain course information for employees receiving CET credit for outside courses. Maintain records for a five-year period from the completion of the two-year period. Obtain a letter of completion or certificate, and retain a record for each employee which reflects:
  - Name of course;
  - Course date(s);
  - Location at which the course was given;
  - Course sponsor; and
  - Number of CET credit hours.
- Submit, to the appropriate RO, an annual certification by January 31 following the close of any calendar year, stating that it is complying with the CET requirements.

E – General Guidelines for Training Courses

*C*ontinuing education and training may include such topics as current developments in audit methodology, accounting, assessment of internal controls, principles of management and supervision, financial management, statistical sampling, evaluation design, and data analysis. It also includes subjects related to the auditors' specific field of work. The contractor shall consider the following sources when developing a training program for auditors:

- Recognition for Courses Needed for CPA Licensing – In meeting the overall 80-hour requirement, courses approved or recognized by the AICPA or the respective state licensing board that contribute to the auditors' professional proficiency are recognized for purposes of meeting the CET requirements.
- CMS-Sponsored Training – From time to time, CMS may contract with vendors to provide training courses and will notify you of their availability. In addition, CMS may offer training in settings such as a national audit conference.
- Contractor-Sponsored Training – The contractor should obtain sponsorship status for its training courses through its respective state CPA licensing board. This will help to ensure that the courses will meet the CET requirements. Also, the courses will be recognized for CPAs on your staff that is required to obtain continuing professional education credits for CPA licensure. In the development of in-house training, the contractor shall consider the AICPA's Statement of Standards for Formal Group and Formal Self-Study Programs. While in-house training is

recognized as the most cost-efficient method of training, the contractor should not rely solely on this method.

- Credit Hours – CET credit may be given for whole hours only, with a minimum of 50 minutes constituting one CET hour. As an example, 100 minutes of continuous instruction counts for two CET hours. However, 50 or more but less than 100 minutes of continuous instruction only count for one CET hour.

A conference in which individual segments may be less than 50 minutes is counted as one program, rather than several short programs. The total minutes of all segments will be divided by 50 minutes in order to determine the CET hours for the program.

For a college or university course, each unit of credit earned on a semester system will equal 15 CET hours. Each unit of credit earned on a quarterly system will equal 10 CET hours.

- Credit for Instructor Preparation Time – When an instructor or discussion leader serves at a program for which participants receive CET credit, and is at a level that increases professional competence, the contractor shall give CET credit for preparation and presentation time measured in terms of credit hours. For the first time a program is presented, CET hours will be received for actual preparation time, up to two times the class hours. For example, if a course is rated as eight CET hours, the instructor should receive up to 24 hours of CET credit (16 hours for preparation and eight hours for class time). For repeated presentations, the instructor should receive no credit unless the subject matter has changed sufficiently to require additional study or research. In addition, the maximum credit for preparation should not exceed 50 percent of the total CET credit an instructor or discussion leader accumulates in a two-year CET reporting period.
- Individual Study Programs – Individual study programs that may receive CET credit include correspondence courses and courses given through audiocassettes, tapes, videotapes, and computers. (See the AICPA's standards for more detailed requirements.)

F – Staff Qualifications

Qualifications for staff members conducting Medicare audits include:

- A knowledge of the methods and techniques applicable to Medicare auditing, and the education, skills, and experience to apply such knowledge to the audit being conducted;

- A knowledge of the Medicare program;

- Skills to communicate clearly and effectively, both orally and in writing; and

- Skills appropriate for the audit work being conducted.

80.3 – Due Professional Care

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

The third general standard for government auditing is:

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

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

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

A – Materiality and Significance

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

B – Relying on the Work of Others

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

C – Audit Follow-Up

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

D – Audit Scope Impairments

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

80.4 – Internal Quality Control

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

The fourth general standard for government auditing is:

"Audit organizations conducting government audits should have an appropriate internal quality control system in place and participate in an external quality control review program."

Establish an internal quality control program and provide reasonable assurance that your Medicare audit department:

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

A – External Quality Control Review (Review of the Internal Quality Control System)

OIG will perform an external review of your internal quality control system. CMS will also review your internal quality review program as part of the Audit Quality Review Program (AQRP) or using other review mechanisms. Any tests of your internal quality control system must evaluate:

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

B – Establishment of an Internal Quality Control System

Establish internal quality control policies and procedures for your Medicare audit department, i.e., all Medicare audit and payment related activities. Communicate these policies and procedures to Medicare audit personnel. While the objective of internal quality control systems is always the same, the nature and extent of such systems can vary based on a number of factors. Normally, documentation of internal quality control policies and procedures would be expected to be more extensive in a larger contractor than a smaller contractor, and more extensive in a multi-office contractor than in a single-office contractor. Therefore, in developing such a system, consider the following factors:

- The size of its Medicare audit department;

- The degree of operating autonomy allowed to your personnel and audit offices;

- The nature of your work;

- Your organizational structure; and

- The cost effectiveness of an internal quality control system.

C – Elements of Internal Quality Control

In addition to the other elements of Generally Accepted Auditing Standards (GAAS), consider each of the elements of internal quality control listed below, to the extent applicable to your operating environment, in establishing your internal quality control policies and procedures. The nine elements of internal quality control taken from the AICPA Statements of Quality Control Standards are:

- Independence – To be free from financial, business, family, and other relationships involving the provider when required by the profession's code of conduct.

- Consultation – To have personnel seek assistance, when necessary, from competent authorities, so that accounting or auditing issues are resolved properly.

- Assignment of Personnel to Audits – To have personnel on the job who have the technical training and competence required for the circumstances.

- Supervision – To determine that work is planned and carried out efficiently and in conformity with professional standards.

- Advancement – To have people at all levels of responsibility that are capable of handling the responsibilities involved.

- Hiring – To have competent, properly motivated people of integrity involved in audits.

- Professional Development – To provide staff with the training needed to fulfill their responsibilities and to keep them abreast of current developments.

- Acceptance and Continuance (fraud and abuse) – To anticipate potential problems with providers where fraud or abuse is suspected.

- Inspection – To conduct periodic internal reviews to be sure that the other elements of the internal quality control system are working.

D – Application of the Elements of Internal Quality Control to the Medicare Environment

(1) Independence

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

- Designate an individual or group to provide guidance and to resolve questions of independence matters.
- Communicate, in writing, the policies and procedures relating to independence to personnel at all levels.
- Obtain the confirmation of independence of firms engaged to perform audits or segments of audits. Obtain a separate representation for each audit.
- Obtain from your personnel periodic, written representations of their independence on an annual basis, stating that:
  - They are familiar with your independence policies and procedures.
  - Financial interests in providers and related entities are not held and were not held during the period. Any such financial interests must be listed, detailing the number of shares or the dollar amounts.
  - Personal, professional, or family relationships with providers and related entities do not exist and did not exist during the period. List any relationships with an explanation, including the names of the parties to the transaction.
  - There were no transactions that might impair the extent of inquiry or disclosure, or affect audit findings in any way. List any transactions with an explanation, including the names of the parties to the transaction.

(2) Consultation

Establish policies and procedures to provide reasonable assurance that staff will seek assistance, to the extent necessary, from persons having the appropriate levels of knowledge, competence, judgment, and authority. You must:

- Maintain technical manuals (e.g., SAS) and Medicare manuals.
- Issue memoranda or other pertinent material to staff regarding Medicare payment issues.
- Inform staff of procedures to follow in resolving technical problems, including referrals to CMS and industry associations.
- Maintain subject files containing the results of consultations for reference and research purposes.

(3) Assignment of Personnel to Audits

Establish policies and procedures to provide reasonable assurance that persons who are assigned to perform audits have the degree of technical training and competence required for the circumstances.

Describe the method used to assign professional personnel to audits, including:

- The basis on which assignments are made;
- How staff are advised of their assignments, whether orally or in writing;
- Who is responsible for making staff assignments on a day-to-day basis; and
- How staff are informed of estimated time requirements and of any special skills or experience that a given assignment may demand.

(4) Supervision

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

Assure that the policies and procedures for planning, performance, and supervision of audits meet *audit* standards of quality. You must:

- Provide procedures for planning individual audits in accordance with Medicare instructions, such as:
  - The development of proposed audit programs;
  - The determination of staffing requirements and the need for specialized knowledge; and
  - The development of estimates of time required to complete the audit.
- Provide procedures for maintaining standards of quality for work, such as:
  - Guidelines for the form and content of working papers;
  - Procedures for resolving differences of professional judgment among members of an audit team; and
  - Standard forms, checklists, and questionnaires appropriate to assist in the performance of audits.
- Provide procedures for reviewing audit working papers and reports.

(5) Hiring

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

- Plan for staffing needs at all levels;
- Establish quantified hiring objectives based on current workload, anticipated changes in workload, staff turnover, individual advancement and retirement, and current Medicare budget; and
- Establish qualifications and guidelines for evaluating potential hires at each professional level.

(6) Professional Development

Establish policies and procedures for professional development to provide reasonable assurance that staff will have the knowledge required to enable them to fulfill assigned responsibilities and to progress within your Medicare audit department. The Professional Development Standard of internal quality control addresses the appropriateness of the professional education to the achievement of audit quality. You must:

- Establish a plan for meeting its CET requirements and communicate it to Medicare audit staff; and
- Provide for on-the-job training, such as varying assignments among audit staff, assigning staff to different supervisors.

(7) Advancement

Establish policies and procedures for advancing staff to provide reasonable assurance that those selected for advancement have the qualifications necessary for fulfillment of the responsibilities assigned. You must:

- Specify qualifications deemed necessary for the various levels of responsibility within its Medicare audit department; and
- Evaluate the performance of personnel and periodically advise staff of their progress. Maintain personnel files containing documentation relating to the evaluation process.

(8) Acceptance and Continuance (Fraud and Abuse)

The usual considerations for acceptance and continuance of clients of CPA firms are not applicable to the Medicare audit environment. Although the nature of the relationship with the audit subject is materially different from that experienced by a CPA firm, there is equivalent concern with a Medicare audit in which fraud and abuse is suspected. Accordingly, make a full and immediate disclosure to your CMS RO and to the OIG, as appropriate, of suspected or detected fraud, abuse, illegal acts, or material misstatements

or misrepresentations on the part of any provider, other organization or individual. (See §140ff of this chapter.)

(9) Inspection

Establish policies and procedures for inspection to provide reasonable assurance that the procedures relating to the other elements of internal quality control are being effectively applied. Monitor the effectiveness of inspection policies and procedures. Develop the procedures for inspection and ensure that inspections are performed by individuals acting on behalf of your management. You must:

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

90 – Final Settlement of the Cost Report

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

CMS expects that you settle (i.e., issue a Notice of Amount of Program Reimbursement (NPR)) all cost reports that are not scheduled for audit within 12 months of acceptance of a cost report *unless you have a documented reason why the cost report cannot be settled (for example bankruptcy, OIG investigation, DOJ investigation). If a provider files an amended cost report and that cost report is not going to be audited, CMS expects that you settle the cost report within the greater of 5 months from the acceptance of the amended cost report, or the time left of the 12 months from the acceptance of the "initial" filed cost report.*

If you audit a cost report, issue the NPR to the provider within 60 days of the exit conference or within 60 days after the audit adjustments are finalized (using the timeframes described in §60.11 of this chapter) if an exit conference is waived.

As a general rule, if proper notification was given to the provider (see §§60.1 and 60.2 of this chapter) and adjustments were proposed due to the "lack of documentation" as described in 42 CFR 413.20 and 42 CFR 413.24, issue the NPR without considering documentation received from the provider after the established timeframes unless there are circumstances that you have previously approved.

If the provider used the PS&R settlement data to file the cost report or if you decide to use the PS&R data because the provider's reported settlement data is not documented properly, settle the cost report using a PS&R with a paid through date no earlier than 120 days prior to the issuance of the final audit adjustment report. If you do not issue an audit

adjustment report (e.g., there were no desk review exceptions resolution process adjustments or field audit adjustments), use a PS&R with a paid through date that is no earlier than 120 days prior to the NPR date. If you settle the cost report later than 18 months after the end of the provider's fiscal year, use a PS&R with a paid through date that is no earlier than 15 months after the end of the provider's fiscal year.

120.4 – Timing and Completion of Home Office Audits

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

Home offices of chain organizations are not providers, thus their costs are not directly payable by Medicare. Home office costs are payable only when they are allocated to the providers in the chain and become part of the providers' allowable costs. Since the allocation of home office costs usually affects all providers in the chain, the audit of the home office cost statement should be performed by the responsible/designated contractor as soon as possible after the receipt of the home office cost statement so that the servicing contractors can expeditiously finalize the settlement or reopening of provider cost reports pending the results of the home office audit. *CMS expects that if a home office cost statements is not scheduled for an audit, the cost statements should be finalized within 12 months from the date of acceptance. This is effective for all home office cost statements received on or after October 2005.*

When you as the responsible/designated contractor begin the audit of the home office cost statement, notify all the other contractors that service the providers within the chain and keep them informed of the progress of the audit and any significant developments. Also, notify the servicing contractor(s) if during the audit you identify adjustments that may affect other providers within the chain that are not being audited. After such notification, you may need to expand the scope of the home office audit if a servicing contractor requests that you audit the issue on site because it is not possible for that contractor to resolve it any other way. In this situation, the servicing contractor should assist you in preparing the expanded audit steps and forward to you any working papers that you may need.

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

120.8 – Acceptance of Home Office Cost Statements

(Rev. 84, Issued: 11-16-05; Effective Date: 12-05-05; Implementation Date: 12-05-05)

CMS expects the contractor to make determination of acceptability within 30 days of receipt of a home office cost statements.