Program Memorandum Intermediaries

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

Transmittal A-01-82 **Date: JULY 3, 2001**

CHANGE REQUEST 1468

SUBJECT: Center for Medicare and Medicaid Services (CMS) Audit and Cost Report Settlement Expectations

Purpose:

The purpose of this Program Memorandum (PM) is to clarify CMS's expectations of how you will manage, audit and settle Medicare cost reports. You may need to change the way you conduct and manage your audit and cost report settlement activities to come into compliance with these expectations.

Discussion:

We will revise the Intermediary Manual, Part 4 to reflect the changes/additions in this PM. In carrying out your audit responsibilities, your primary goal is to arrive at a correct settlement of the cost report. In so doing, preserve the provider's interest and rights. In carrying out your audit responsibilities, apply program policies to specific situations to assure compliance with these policies. Your authority does not extend to determining whether program policies and procedures are appropriate or should be applied in a given circumstance. Rather, your responsibility is to enforce such policies and procedures. Take corrective action where noncompliance exists.

Provider Communication

CMS expects each INTERMEDIARY to notify their providers of the key issues regarding the audit and settlement process. Attached is a sample fact sheet that highlights the issues we expect INTERMEDIARIES to communicate. Please communicate this information in your next provider bulletin. If possible please post this information on your web site.

Audit Management:

Since the issuance of the revised government auditing standards (GAS), effective January 1, 1995, our understanding and expectation of the way Medicare audits are managed and conducted have changed. National audit conferences, as well as recent developments, point to this change. We expect you to use properly documented professional judgment and prudent management practices that are consistent with relevant professional standards (GAS and American Institute of Certified Public Accountants) in carrying out your audit responsibilities.

PS&R Data Reports:

The Provider Reimbursement Manual, Part 2, directs providers to use the information contained in the provider statistical and reimbursement report (PS&R) to prepare their Medicare cost reports. Accordingly, furnish each provider with a year-to-date PS&R summary report in accordance with the Provider Reimbursement Manual, Part 2, Chapter 1 by the 120th day after the end of the provider’s cost reporting period from which the cost report will be prepared. Even though the PS&R data may change by the time the cost report is filed, i.e., as claims continue to be processed, provide the PS&R summary within the 120-day period. In addition, a provider may request detailed PS&R data (e.g., payment reconciliation report) to reconcile their records with your records. If such a request is received, furnish an annual detailed PS&R at no cost to the provider.

Providers may also request interim (other than annual) detailed PS&R data. If such requests are received, provide the detailed data at intervals requested by the provider as long as they are reasonable. You may charge the provider a fee for this extra service. Your fee should be reasonably related to costs you incur for the added service, and be commensurate with your charge to all other providers for providing similar data.

Wherever possible, furnish PS&Rs through automated media (e.g., computer diskette, magnetic tape, and microfiche). Furnish hard copy only as a last resort.

Cost Report Submission:

All providers are required to submit a cost report within 5 months of the cost reporting fiscal year end or 30 days after a valid PS&R is sent to the provider by the intermediary, whichever is later. If the provider fails to submit a cost report timely or if the cost report is rejected, stop all payments to the provider and prepare a demand letter for all previous payments. Issue the demand letter as soon as possible but no later than 30 days after the due date of the cost report.

An acceptable Medicare cost report means that all of the items in Part I of the Acceptability Checklist have been included in the submission. This includes:

From all providers filing electronic cost reports (ECRs):

1. A diskette of the ECR utilizing a CMS-approved vendor with the current specification date submitted.

2. An ECR that passes all Level 1 edits.

3. A submitted print image file of the cost report except when using CMS free software.

4. The certification page (Worksheet S) of the ECR file with the actual signature of an officer (administrator or chief financial officer).

5. An exact match of the encryption code, date and time for the ECR displayed on the certification page to that of the ECR file encryption code, date and time.

6. An exact match of the encryption code, date and time for the print image displayed on the certification page to that of the print image file encryption code, date and time except when using CMS free software.

7. For teaching hospitals, a complete Intern and Resident Information System (IRIS) diskette that will pass all IRIS system edits.

8. The settlement summary on the electronic certification page agrees with the settlement summary on the Medicare cost report produced from the electronic file. (Prior to rejection confirm that the settlement summary difference is not caused by the intermediary automated data reporting (ADR) vendor system.)

9. A completed, signed and submitted Form HCFA-339 with an original signature.

From all other providers:

1. A completed and legible cost report on the proper forms.

2. A general information and certification page which includes the original signature of an officer (administrator or chief financial officer).

3. A completed, signed and submitted Form HCFA-339 with an original signature.

Additionally, the following items (1-7) must be submitted with the provider's cost report. However, if the provider fails to submit any of these items, do not reject the cost report; instead, immediately notify the provider in writing that its cost report submission was incomplete. Allow the provider 15 days from the date of the letter to provide the missing documentation; otherwise, the cost report will

be rejected. If the provider fails to provide the required documentation within the prescribed timeframes, begin the demand letter process.

For all providers as appropriate, ensure that the items from Part II of the Acceptability Checklist are present. This includes:

1. Correctly updated graduate medical education (GME) per resident amounts.

2. All applicable documentation required per Form HCFA-2552-96 (Complete Exhibit A of the Acceptability Checklist to verify the submissions).

3. All required documentation per Form HCFA-339 (Complete Exhibit B of the Acceptability Checklist to verify the submission)

4. Documentation supporting exceptions to level 2 ECR and hospital cost report information system (HCRIS) edits.

5. A copy of the working trial balance.

6. A copy of the audited financial statements where applicable.

7. Where applicable, the supporting documentation for reclassifications, adjustments, related organizations, contracted therapists, and protested items.

Never accept a cost report package that is materially incomplete. Materially incomplete means any of the items 1-9 and 1-3 above and items 1-7 above that are not received in the time allowed.

NOTE: Home office cost statements are to be submitted within 150 days of the Chain Home Office's fiscal year's end. If the Chain Home Office fails to submit a cost statement within that time frame, notify the Chain Home Office of its failure to submit a cost statement and the servicing intermediaries to issue a demand notice requiring repayment of Home Office Costs. The servicing intermediaries are required to reduce interim payments to the providers to reflect the disallowance of any Home Office costs.

Initial/Tentative Retroactive Adjustments (a.k.a. Tentative Settlements):

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

For the purpose of initial/tentative retroactive adjustments, accept costs as reported. However, in accepting the cost filed on the cost report, you must also consider your past audit experience with the provider. That is, do you consistently make adjustment to the costs, or are there errors in implementing program policy? Also give consideration to amounts owed the program by the provider, e.g., unrecovered overpayments, as well as possible adjustments for prior periods and current period unresolved issues.

NOTE: In instances where a provider is in or part of a bankruptcy, bankruptcy procedures will supercede this part of the PM.

Planning and Resource Management

Annually, through the budget process and the budget performance requirements (BPRs), CMS gives you guidance for managing audit resources in terms of units of work expected to be completed during a fiscal year and dollars available to accomplish the tasks. Since it is easy to translate this expectation into terms that yield an average number of hours to be used in completing a work product, some audit managers have interpreted the BPRs as limiting the number of hours that are used on any one-work product. However, application of an average number of hours in the

individual audit setting must be weighed against the responsibility to use due professional care in managing audit resources and conducting audits. The BPRs in no way restrict the number of hours available or expand the scope of work for any particular audit.

Apply the appropriate level of resources for each audit to assure that payments made to a provider are not more or less than required under applicable law and regulations to achieve CMS's audit objectives. If you are unable to meet both the quality standards and the BPRs' guidelines, seek guidance from your regional office (RO) on the extent to which you may deviate from the BPRs while maintaining audit quality.

Effective management of audit resources requires a continual decision-making process. Develop an audit plan to identify cost reports to be audited and resources to be expended, taking into consideration guidance that CMS gives you about the types of providers or potential issues to be audited. However, the plan cannot be static. As events occur throughout the audit cycle and circumstances come to light, the audit plan must be continually evaluated and priorities reassessed. If a greater audit requirement becomes evident, do not defer that audit work. Rather, defer or cancel audit work of lesser urgency. If there is no work of lesser urgency, seek guidance from the RO.

You are expected to accomplish the goals outlined in BPRs to the extent that other audit needs that are discovered during the year do not outweigh these goals. Use professional judgment to communicate workload adjustment needs to your RO. Monitor your progress on BPRs and discuss the impact of any problems that may develop in meeting the BPRs with your RO.

Use CMS audit priorities as a guide in deciding which providers to audit and areas to cover. Do not use these priorities as the sole determining factor in the planning process. The planning process is based on your empirical knowledge, past performance of the provider, last time audited, and the relative risk associated with the settlement amount calculated from the cost report. Generally, select providers for audit that, based on your professional judgment, represent the greatest risk for incorrect payment. This risk should be consistent with the nature of the audit (e.g., settlement or rate setting).

Audit Scoping:

Your desk review process helps you to refine your judgments about which providers should be subjected to a field audit and assists in the determination of issues to be addressed for each of the providers selected. The audit scoping process starts with these issues, and you select the appropriate audit procedures to be included in the audit program for that provider. The results of the desk review also support your decisions about which providers not to audit or which issues not to pursue during audit.

In developing your field audit scope, if you decide that issues that were identified as exceptions in the Uniform Desk Review should not be scoped for audit, document and support the decision in your separate desk review working papers/files.

In addition to field audits, CMS allows you to perform "focused reviews." A focused review is intended to focus limited audit resources (average of 90 hours) on specific payment issues which you select prior to the start of the fiscal year based upon empirical knowledge of problems and concerns. As a result, perform only those desk review procedures which are listed in the Intermediary Manual, Part 4, §4104.2.B, that apply to the issues to be focus reviewed.

Follow the directives in the Intermediary Manual, Part 4, §4104.2.B and the BPRs in planning and conducting focused reviews. However, note that CMS neither mandates nor encourages you to perform focused reviews on the same provider year after year, especially if the focus is on the same issues. Vary your audit plan to alternate field audit and focused reviews for any given provider. The information obtained from a full Professional Desk Review and a field audit will increase your empirical knowledge of problems and concerns that you can address in future focused reviews for the provider.

Be specific in documenting the issues to be addressed in your field audit or focused review. For example, instead of listing "bad debts" as the area to be audited, specify that you intend to review "collection effort" or "120-day rule."

If you recognize that the need to spend additional resources on a particular audit outweighs the potential benefit of some planned future work, defer the future work and document the reasons in your audit-planning file. However, consult with your RO as necessary prior to proceeding with the audit and deferral of the future work (see the section on BPRs).

Audit Program:

Prepare an audit program for each field audit and focused fieldwork review that you perform. (Use the CMS hospital, home health agency and skilled nursing facility audit programs as a guide where applicable.) Prepare the audit program in conjunction with your field audit and focused review criteria. Your audit program must:

- Identify your audit objectives;
- Identify the issues, transactions or cost report entries to be audited, reviewed or verified;
- Identify the audit steps to be performed;
- Describe the tests to be applied;
- Be cross-referenced to specific working paper pages and entries; and
- Be retained in your working papers.

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

Audit Scheduling

In the engagement letter to the provider (an example letter is attached), give a minimum of 4 weeks and a maximum of 6 weeks notice of your intent to make a field work visit for the purpose of conducting a field audit or focused review. The engagement letter must include the following:

- A list of the required documents that are to be made available by the provider on the first day of the audit.
- Date of the entrance conference and a suggested time.
- Projected time that you will need to conduct fieldwork at the provider
- A request for a contact person from the provider for the field audit.
- A tentative exit conference date set 2 to 3 weeks after the field work is expected to be complete.
- Notice to the provider that all documentation and records requested prior to and during the field work time must be given to you in a timely manner and that failure to produce the documentation will result in non-negotiable audit adjustments. In addition, inform the provider that as a general rule you will not honor any reopening requests for the "lack of documentation" adjustments nor will you administratively resolve any appeal request for the same "lack of documentation" adjustments. This policy has no impact on the normal provider appeal rights with the Provider Reimbursement Review Board.

CMS is mandating that the following policy be utilized for obtaining appropriate documentation from a provider during all audit or focused review fieldwork visits:

- You must send the provider a letter as detailed above providing proper notification of the fieldwork visit.

- At the start of the visit, inventory the provider-prepared documentation noting any items missing from the initial engagement request. Notify the provider in writing of all missing items and request that the items be made available as soon as possible. Follow the same notification policy for any additional documentation that is requested during the audit.

- Conduct an entrance conference with the provider explaining the purpose of the field audit and stress the need for cooperation especially concerning the release of documentation by the provider. You must also inform the provider that if supporting documentation is not received as a general rule you will disallow the costs and not reopen the cost report after the notice of program reimbursement (NPR) is issued.

- Schedule a pre-exit conference for the last day that the audit team will be conducting fieldwork. You should have made the provider aware of the adjustments that are proposed on a flow basis. Give the provider a copy of all adjustments and workpapers (where requested by the provider) including those being proposed due to lack of documentation. Be prepared to discuss all tentative adjustments with the provider. Also, give the provider a list of any outstanding documentation that was requested but has not been received to date. Inform the provider that they will have 4 weeks to provide any additional documentation to the audit staff. Establish an exit conference date that will allow sufficient time for review of any additional documentation that the provider may provide. The pre-exit and exit conferences can be performed telephonically.

- Review any additional documentation that the provider may submit. Do not consider any documentation that is received after the timetable provided at the pre-exit conference, unless prior arrangements with the provider have been made. Where appropriate make changes to the audit adjustments and prepare the final draft adjustment report for release to the provider at exit. All providers must be given an exit conference unless the provider specifically waives the exit. All adjustments must be given at the final exit conference.

- Within 75 days of the exit conference, issue an NPR and a final adjustment report to the provider.

NOTE: Where proper notification to the provider, as explained above, has been given and adjustments were proposed due to the "lack of documentation" as described in 42 CFR 413.20 and 42 CFR 413.24, you are to:

- Issue final determination of allowable costs without considering documentation received from the provider after the established timeframes unless there are circumstances that you have previously approved.

- Consider the provider's culpability in failing to submit proper supporting documentation on a timely basis when you are rendering a decision on the allowability of a reopening and when prioritizing issues for administrative resolution if a timely appeal is filed.

NOTE: While you should not refuse to accept documentation, you should refuse to consider it in the initial NPR issuance. If a reopening is later granted or a timely appeal is made, the late documentation may be considered at that time.

The provider may still appeal any documentation-related issues to the Provider Reimbursement Review Board. Handle all other requests that do not relate to the "lack of documentation" issue described in this section, using your normal process. Also, the notifications to the provider must be included as part of your workpaper documentation.

Field Work:

Your field work must reflect the audit work necessary to satisfy the audit scope and the focused review objectives in your audit program. Use audit tests and procedures that are designed to meet these objectives. Also, fieldwork must comply with the fieldwork standards as found in the June 1994 GAS revision.

Designing Tests:

Design such tests as are necessary to accomplish your audit objectives. Your tests must aid you in reaching conclusions necessary to complete the audit and complete the audit objectives. Use statistical sampling techniques when this would be more efficient in testing the universe of transactions or entries within an area of consideration.

When statistical sampling is used:

- Document your sampling techniques.
- Document the confidence level of your sampling approach.
- If the results of testing your sample indicate probable error in the universe of transactions or entries, document your decision to either expand your sample and/or to project the error to the universe.

NOTE: Under no circumstances should you make an adjustment for the amount of error in the sample without considering the effect on the universe.

Reliance on Other Auditor's Work:

Audits you perform are generally limited in scope and intended to arrive at the correct settlement of Medicare cost reports. In addition, audits are generally limited to tests of compliance with Medicare policies and procedures. In performing these audits, you generally rely on the financial statements prepared by independent auditors. This includes the independent auditors' review of provider accounting systems.

To the extent that an independent auditor issues an unqualified opinion on a provider's financial statement, and has not identified any material weaknesses in the provider's internal control structure, rely on the provider's system of accounting, including related computer systems to the extent that it supports the provider's financial statements. This does not include reliance on records or systems that are maintained solely for purposes of completing a Medicare cost report.

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

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

Evidence:

Base your audit tests on the best evidence available. Consider the probative value of evidence offered in context of the hierarchy of order and types of evidence. Never rely on evidence of a lower order or type if you can reasonably conclude that evidence of a higher order or type is available to the provider. Insist that providers produce evidence of the highest order and type that you believe is available.

- Order of evidence (high to low)
  - -- Conclusive;
  - -- Convincing; and
  - -- Persuasive.
- Types of evidence (high to low)
  - -- Physical;
  - -- Documentary;
  - -- Analytical; and
  - -- Testimonial (by itself this level of evidence is unacceptable. There must be supporting documentation).

Working Papers:

Your working papers are the evidence of the work you perform. They must stand on their own without the need for supplemental explanation or documentation. Adhere to standard format (purpose, source, scope, and conclusion), indexing and referencing conventions in preparing your working papers. All working papers must be complete and legible.

Listed below are the minimum requirements for your working papers:

- The auditor must put his or her name and the date prepared on each page of the working papers.
- Prepare a working paper for each audit procedure or test that includes:
  - -- A statement of the purpose of the procedure or test;
  - -- A description of the scope of the procedure or test;
  - -- A statement describing the source of the information obtained;
  - -- A description of the information obtained, including copies or samples, as appropriate, of actual documents examined; and
  - -- A statement of the conclusions drawn based on the procedures or tests performed on the information obtained.
- Prepare lead sheets and summaries, as appropriate, that relate to the scope of your audit.
- Cross-reference all working papers to the lead sheets, summaries, audit program and the adjustment report.
- Prepare an index to your working papers for ease of reference.

- Each page of completed working papers must include the supervisory reviewer's initials and date reviewed.

- Retain all supervisory review notes in the working papers.

- Provide adequate storage for the safekeeping of working papers.

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

Reconciling Adjustment Report with Working Papers and Revised Cost Report:

Reconcile your adjustment report with the revised cost report and your working papers to assure that every adjustment listed on the adjustment report is documented in the working papers and included in the final settlement. Assure that every adjustment identified in the working papers is included on the adjustment report or, if not included, that the working papers contain sufficient rationale explaining why the adjustments were not made.

Supervisory Review:

GAS requires you to perform an adequate supervisory review of every audit. This may require several levels of review, depending on the size and configuration of the audit organization. For example, in a larger organization, the in-charge auditor is responsible for reviewing the work of other auditors on the team, and an independent supervisor reviews all work performed in the audit.

While the ideal situation would have this second level review performed by an audit supervisor, the individual performing that function need not have that title. Rather, the individual may be a highly qualified senior auditor who is not part of the team performing the audit. In addition, a manager may also perform a subsequent higher level review of the completed work.

Your responsibility to review includes audits performed by all your employees and by individuals who are not your employees (i.e., subcontractors), regardless of the arrangements under which they perform the audits. You cannot delegate the responsibility to perform independent reviews of a subcontractor even if the subcontractor is another fiscal intermediary.

An independent review requires you to review all working papers to ensure that:

- All adjustments identified during the audit were made, or if not made, that the audit include sufficient rationale explaining why they were not made.

- The provider has been advised of proposed adjustments and given sufficient time to respond.

- The objectives of the audit were met.

- The audit program is appropriately cross-referenced to the audit procedures.

- The conclusions drawn from the audit procedures are supported by the work performed.

- The conclusions are supported by sufficient, competent, and relevant evidential matter.

- Medicare payment policies are properly applied.

- The mechanical and analytical requirements of adequate working papers are met.

- The working papers include adequate consideration of a provider's system of internal controls. (This may consist of a statement of why the auditors decided not to rely on a provider's system of internal controls. Where the auditors decide to rely on a provider's system of internal controls, the working papers must include documentation of the risk assessment.)

- Additional issues identified during the course of the audit are adequately addressed or appropriately deferred.

- Decisions to defer audit steps identified during the initial audit scoping are adequately documented.
- Notes for future audits are prepared and filed properly.

Retain supervisory review notes in the working papers.

Managing an Effective Internal Quality Control (IQC) Program:

In addition to your responsibilities for developing internal controls in the audit and reimbursement area, CMS expects that you manage an effective IQC program. Your responsibilities for IQC are described in the Intermediary Manual, Part 4, §4112.3.D.

The inspection element of IQC requires you to review a sufficient sample of work products (in addition to the reviews performed to meet your supervisory review expectations) to achieve a reasonable assurance that the work performed meets applicable standards. The work to be reviewed during your inspections must include all activities contributing to the settlement of cost reports that are normally within the control of the audit and reimbursement department.

The monitoring function of IQC requires you to have processes in place to assure yourself that all of the elements of IQC are in place and working effectively. Activities undertaken in satisfaction of the monitoring requirement must be fully documented. This documentation must be available for review upon request by CMS or its agents.

Settlements:

Effective with this PM, CMS expects that all cost reports that are not scheduled for audit or focused reviews must be final settled within 12 months of acceptance of a cost report. Otherwise, in accordance with 42 CFR 405.1835, the provider has the right to a hearing for lack of a timely settlement.

In addition, all reopened cost reports should be settled within 180 days of receipt of any remaining information/data necessary to resolve the issue. In normal circumstances the provider should submit documentation within 60 days of notice from the intermediary. Discuss with the RO, any situations where unforeseen circumstances prevent you from meeting these expectations.

Attachment 1 provides language to advise providers that they have been selected for review.

Attachment 2 provides a fact sheet listing our audit and cost report expectations.

ATTACHMENTS

The effective date for this PM is for data requests on or after September 1, 2001.

The implementation date for this PM is September 1, 2001.

The instructions contained in this PM should be implemented within your current operating budget. Information in this PM should be considered during FY 2002 budget negotiations.

This PM may be discarded after December 31, 2001.

If you have any administrative questions, contact David Goldberg (410-786-4512).

If you have any technical questions, contact Jerry Mulcahy (410-786-3374).

ATTACHMENT 1

Any Provider USA
Main Street, State, USA

Dear Provider;

This is to inform you that your facility has been selected by (intermediary name) for a field audit/focused review of your YYYY cost report. The audit will commence on MM, DD, YYYY, (4 weeks from the date of the letter) with an entrance conference to be held the day we arrive on site. Please arrange for a conference room or adequate space for this meeting. We ask that at the least the chief financial officer, the person who prepared the cost report, and anyone designated as your liaison for the audit is present at the entrance conference. In addition, we ask that the information listed on the attached schedule be available on the date we arrive. This list will enable you to accumulate the necessary documentation we will need to begin the audit prior to the entrance conference.

If you need to postpone the audit entrance date, please notify us 2 weeks prior to the scheduled audit and we will attempt to accommodate your request. This is necessary as our audit work plan has been set and we will need time to reschedule the audit staff. Again all documentation found on the attached list must be available at the entrance conference. This will enable us to review the information and expedite our audit process while minimizing the impact on your personnel. Be aware that this list is not all-inclusive and that we may request additional documentation necessary to conduct and complete our audit. If the information is not provided, we will make audit adjustments to disallow the costs associated with the requests.

Any proposed audit adjustments will be given to you during the course of the audit. You may request the work papers that support the adjustments at any time. A pre-exit meeting will be held on the last day of the audit fieldwork. In this meeting we will go over outstanding information requests and all of the audit adjustments available at that time (other adjustments may result either from a supervisory review of the work or additional information provided for outstanding items). You will have 4 weeks to provide any outstanding information or information to refute any previously proposed audit adjustment. The final adjustments will be provided to you 2 weeks after we receive any outstanding information. **We will not accept any additional documentation from you after the expiration of the 4-week period related to the outstanding documentation discussed at the pre-exit conference. In addition, as a general rule, we will not reopen the cost report or administratively resolve these issues resulting from lack of documentation.**

If you wish to have or waive a formal exit conference you must contact the audit and reimbursement manager within 10 days of the date of the pre-exit conference. Once the exit conference is held the notice of program reimbursement will be issued 75 days from the exit conference. We believe these time frames and requirements will help expedite the completion of the field audit/focused review and settlement of your cost report. These provisions will be uniformly applied to all providers. We believe that with your cooperation we will have better field audits/focused reviews and more accurate settlements of cost reports.

If wish to discuss this matter please contact _____ at _____.

Sincerely:
Audit Manager

ATTACHMENT 2

FACT SHEET

Purpose:

This is to clarify CMS's Audit and Cost Report expectations.

Cost Report Submission:

Providers must use the information contained in the provider statistical and reimbursement report (PS&R) to prepare their Medicare cost reports. All providers are required to submit a cost report within 5 months of the cost reporting fiscal year end (FYE) or 30 days after a PS&R is sent to the provider by the intermediary whichever is later.

Medicare cost report submission requirements:

From a hospital provider or other providers filing electronic cost reports (ECRs):

1. A diskette of the ECR utilizing a CMS approved vendor with the current specification date submitted.

2. An ECR that passes all Level 1 edits.

3. A submitted print image file of the cost report.

4. The certification page (Worksheet S) of the ECR file with the actual signature of an officer (administrator or chief financial officer).

5. An exact match of the encryption code, date and time for the ECR displayed on the certification page to that of the ECR file encryption code, date and time.

6. An exact match of the encryption code, date and time for the print image displayed on the certification page to that of the print image file encryption code, date and time.

7. For teaching hospitals, a complete Intern and Resident Information System (IRIS) diskette that will pass all IRIS system edits.

8. Agreement of the settlement summary on the electronic certification page with the settlement summary on the Medicare cost report produced from the electronic file.

9. A complete, signed Form HCFA-339 (must be an original signature).

From all other providers:

1. A completed and legible cost report on the proper forms.

2. A general information and certification page which includes the original signature of an officer (administrator or chief financial officer).

3. A complete, signed Form HCFA-339.

For all providers as appropriate, the submitted cost report package must also include:

1. Correctly updated graduate medical education (GME) per resident amounts.

2. All applicable documentation required per Form HCFA-2552-96.

3. All required documentation per the Form HCFA-339.

4. Documentation supporting exceptions to level 2 ECR and HCRIS edits.

5. A copy of the working trial balance.

6. A copy of the audited financial statements where applicable.

7. Where applicable, the supporting documentation for reclassifications, adjustments, related organizations, contracted therapists, and protested items.

The intermediaries will reject a cost report package that does not contain all items identified above. If the last 5 items are not received with the cost report an additional 15 days will be given to submit these items.

Home Office Cost Statements

Home office cost statements must be submitted within 150 days of the Chain Home Office's FYE.

Documentation Guidelines

The provider will be notified in the engagement letter of documentation that is required for the review. This documentation should be available on the first day of the audit. All additional documentation requests will be made in writing. At the pre-exit conference the provider will be given a list of any documentation that is still outstanding. They will have 4 weeks to provide this documentation. If documentation is not received timely all related cost will be disallowed. As a general rule cost reports will not be reopened for documentation that is submitted late.