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 2513

CHAPTERS	REVISED SECTIONS	NEW SECTIONS	DELETED SECTIONS
7	10.1.2 20.1 20.2.1 20.5 30.1 30.2 30.3 30.4 30.5 30.6 40 40.1 40.2 Attachment A Attachment B		

Red italicized font identifies new material.

NEW/REVISED MATERIAL - EFFECTIVE DATE: October 1, 2002
IMPLEMENTATION DATE: March 21, 2003.

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

Section 10.1.2, FMFIA and the CMS Medicare Contractor, clarifies CMS' evaluation of Medicare contractors.

Section 20.1, Risk Assessment, clarifies who should perform the risk assessment.

Section 20.2.1, FY 200*3* Medicare Control Objectives, clarifies control objectives made by CMS business owners.

Section 20.5, Documentation and Work Papers, clarifies CMS documentation requirements.

Section 30.1, Requirements, clarifies what is to be submitted to CMS in the Certification Package for Internal Controls.

Section 30.2, Certification Statement, clarifies the wording of statement submitted by Medicare contractors and change in CMS mail stop.

Section 30.3, Executive Summary, clarifies data elements within executive summary, and the assigning CMS finding numbers.

Section 30.4, CPIC- Report of Material Weaknesses, clarifies data elements on report and calculating total number of material weaknesses.

Section 30.5, CPIC- Report of Reportable Conditions, clarifies data elements on report and on calculating total number of reportable conditions.

Section 30.6, Definitions and Examples of Reportable Conditions and Material Weaknesses, provides minor clarifications to definitions**.**

Section 40, Corrective Action Plans, provides clarification regarding types of audits covered by instructions.

Section 40.1, Submission, Review, and Approval of Corrective Action Plans, clarifies initial corrective action plans, how to handle recommendations, and changes in mail stop.

Section 40.2, Universal Corrective Action Plan (CAP) Report, provides clarifications to data elements on universal CAP report.

Attachment A, Universal CAP Report, provides clarifications consistent with Section 40.2, which includes clarification of use of the provided format of the Universal CAP report.

Attachment B, CMS Finding Numbers, provides minor clarifications to CMS finding number format.

10.1.2 - FMFIA and the CMS Medicare Contractor Contract - (Rev. 15, 02-07-03)

The CMS Medicare contract with its Medicare contractors 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. *CMS evaluates* Medicare contractor's performance *by various internal and external reviews*.

To further sensitize the Medicare contractors as to the importance of FMFIA compliance, CMS has been requiring the Medicare contractors to annually provide assurance that 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 expectations, that the Medicare contractor recognizes the importance of internal controls, and has provided required documentation in the package per instructions.

20.1 - Risk Assessment - (Rev. 15, 02-07-03)

Risk assessment identifies areas that should be reviewed to determine which components of an organization'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. *Operational managers with knowledge and experience in their particular business area shall perform risk assessments. Outside sources can assist with this process but should not be solely relied upon (i.e. Internal Audit departments, individual SAS 70 reviews, etc.).* 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 organization'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.

20.2.1 - FY 200*3* Medicare Control Objectives - (Rev. 15, 02-07-03)

Control Number	Control Objective: *Controls provide reasonable assurance that…*
A	***Information Systems***
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.
A.4	Information resources are classified (risk-ranked) according to their criticality/sensitivity and are periodically formally reviewed.
A.5	Access to computerized applications, systems software, and Medicare data is appropriately authorized, documented, and monitored.
A.6	Physical access to Medicare facilities and systems is appropriately authorized, documented, and access violations monitored and followed-up.
A.7	Medicare application and related systems software development and maintenance activities are authorized, documented, tested, and approved.
A.8	Adequate segregation of duties exists between various functions within Medicare operations and is supported by appropriately authorized and documented policies.
A.9	Personnel activities are controlled using approved formal operating procedures and supervision/review of the use of these procedures.
A.10	A regular assessment of the criticality and sensitivity of computerized operations and related supporting resources is performed.
A.11	*Certain regularly scheduled processes required to support the Medicare contractor's continuity of operations in the event of a catastrophic loss of data, facilities or equipment, or to minimize the impact of threats to data, facilities or equipment, are performed as scheduled.*
B	**Claims Processing**

***B*.1** System capabilities and documentation are accessible in the Medicare claims processing system to track a claim from receipt to final resolution.

***B*.2** Data scheduled for processing is valid and errors are rejected.

***B*.3** Claims are processed accurately and in a timely manner in accordance with CMS guidelines.

***B*.4** Claims are reopened when necessary and in accordance with CMS guidelines.

***B*.5** Claim payments are properly calculated and duplicate claims are identified prior to payment.

***B*.6** Claims are properly aged from the actual receipt date to the actual date of payment in compliance with legislative mandates.

***B*.7** Personnel are trained to detect and deter fraudulent and abusive practices.

C **Appeals**

***C*.1** Medicare Part A reconsiderations, 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. ** These are Part B claims processed by Fiscal Intermediaries (FIs). FIs follow the Part B appeals process- reviews and hearings, etc.*

***C*.2** Medicare Part B reviews and hearings processed *by carriers* based on CMS instructions, appropriately logged and completed within legislatively mandated time frames and tracked to meet CMS guidelines.

***C*.3** Administrative Law Judge (ALJ) cases are handled in compliance with *CMS* time frames.

***C*.4** *Departmental Appeals Board (DAB) referral, requests for case files and effectuations are processed* as directed by CMS guidelines.

D **Beneficiary/Provider Services**

D.1 Personally identifiable health information, which is used and disclosed in accordance with the Privacy Act, is handled properly.

D.2 Beneficiary and provider written and walk-in inquiries are *retained and* handled accurately, appropriately, and in a timely manner.

D.3 Telephone inquiries are answered timely, accurately, and appropriately.

E **Benefit Integrity (BI)**

***E.*1** An independent BI unit that is responsible for detecting and deterring potential fraud should be developed and maintained.

***E.*2** Written procedures exist for BI unit personnel to use for the detection and review of potentially fraudulent situations.

***E.*3** Reactive and proactive techniques in the detection and development of potential fraud cases are used especially in the area of data analysis.

***E.*4** Appropriate safeguard and administrative actions are taken when fraud is suspected which should include payment suspension, and payment recovery of overpayments, provider education, referral to OIG, and denials of claims.

***E.*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 other law enforcement officials.

***E.*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.

***E.*7** Procedures established for handling BI unit activities are compliant with the current Program Integrity Manual (PIM) instructions.

***E.*8** Procedures are in place and appropriate action is 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.

***E*.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.

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

***E*.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.

***E*.12** Inventory is properly controlled and monitored.

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

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

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

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

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

***E*.18** Restricted and National Medicare Fraud Alerts are appropriately handled.

***E*.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.

***E*.20** An established quality improvement program exists.

***E*.21** Contractors have incorporated fraud & abuse training into operations.

F **Medical Review (MR)** ***and Local Provider Education and Training (LPET)***

***F*.1** Data analysis is performed to identify aberrant billing practices, potential areas of over utilization, and changes in patterns of care over time

(*minimum of 18 month* trends) by providers and services that present financial risks through incorrect *billings* to the Medicare Program.

***F*.2** Data is used from *a variety of sources including:* CMS *and other national sources,* contractor's internal databases, specialty data analysis contractors (e.g. Statistical Analysis Durable Medical Equipment Regional Carrier (SADMERC) and Program Safeguard Contractor (PSCs)), and *any* other sources available to the contractors to identify *and prioritize* targets for *probe/*focused review.

***F*.3** Edits developed as a result of data analysis are *implemented and are* effective in detecting inappropriate claims. *Effectiveness is analyzed and measured by the denial rate, dollar return on the cost of operationalizing the edit, and billing behavior correction.*

***F*.4** *Effectiveness of edits is evaluated in determining workload level.*

***F*.5** *MR expenditures are consistent with the level of MR workload.*

***F*.6** *Appropriate medical expertise is applied during the MR and LPET process.*

***F*.7** *Workload is reported in accurate, timely, monthly MR IER report, with each activity properly allocated.*

***F*.8** *Workload is accomplished in conformance with the current FY medical review and LPET strategy as communicated by PM.*

***F*.9** *The documented MR Strategy is site and budget specific (i.e., workload and cost by activity) and it is consistent with the goal of reducing the error rate.*

***F*.10** *Current CMS issued instructions (e.g. PCA) are used correctly to improve identification and follow-up of patterns of inappropriate billing.*

***F*.11** *The status of cases can be identified at any time and are closed timely.*

***F*.12** *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.*

***F*.13** *The Contractor complies with all requirements of Joint Operating Agreement with PSCs.*

F.14 *The contractor's LPET program assures providers are notified timely of any new or modified CMS guidelines related to medical review and are educated on appropriate billing practices.*

F.15 *The contractor's LPET program utilizes efficient and effective multifaceted educational activities in various venues to address existing program vulnerabilities and new and emerging problems.*

F.16 *LPET activity selections are based on MR outcomes, and the documented LPET strategy is linked to the MR Strategy, Data Analysis and the Quality Improvement Plan.*

F.17 *Post-LPET intervention data analysis findings are used to evaluate LPET training and intervention effectiveness.*

F.18 *The Medicare contractor's management supports the internal networking and sharing of information on MR activities, potential fraud cases, audits, and MSP.*

F.19 *A quality improvement program with a coordinator dedicated to ensure continuous improvement in all areas of contractors' MR and LPET Program.*

G **Medicare Secondary Payer (MSP)**

***G*.1** MSP provisions *are administered, implemented, enforced and supported* in accordance with current manual requirements*, program memoranda, and desk level procedures. All references must be maintained in an area accessible to MSP staff and must be available for CMS review.*

***G*.2** *Internal quality controls are established and maintained that ensure timely and accurate processing of secondary claims submitted with a primary payer's explanation of benefits (EOB) or remittance advice (RA). This includes utilization of the MSPPAY module, resolving all MSP edits (including 6800 codes), creation of "I" records, documenting RTP claims (i.e., claims that are returned to the provider without adjudication) and resolving suspended claims.*

***G*.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. *All references must be maintained in an area accessible to MSP staff and must be available for CMS review.*

G.4 *A*udit trails for MSP recoveries (receivables) are maintained. *This should also include the contractor's ability to create a complete audit trail if cases are housed or maintained electronically. An audit trail should contain detail to support all accounting transactions as a result*

of establishing, reconciling and resolving a receivable. All correspondence specific to a case should be accessible and in date order.

G.5 *Contractors should have processes and procedures in place to document the path to MSP reporting. This documentation should include procedures to meet required time frames to reporting and ensure all integral components sharing responsibility of MSP reporting have clearly defined roles and expectations. MSP reports must be available and accessible for CMS review.*

G.6 *Contractors have processes and procedures in place to ensure compliance with all CMS instruction and directives relating to Phase III (MSP Investigations) of the Coordination of Benefits Contract. This includes transmitting appropriate, timely and complete ECRS CWF Assistance Requests and ECRS MSP Inquiries as a result of the receipt of a phone call, correspondence, or claim. All references must be maintained in an area accessible to MSP staff and must be available for CMS review.*

G.7 *Contractors have processes and procedures in place to identify and track all incoming correspondence to ensure timely response or acknowledgement. These tracking mechanisms should include the ability to track ECRS submissions when awaiting a particular response/status from the COBC, or if your ECRS submission may warrant further action after COBC development/investigation (e.g., claims adjustments, recoveries); document the relationship and outcomes specific to active cases, both those where a receivable has been established and those where a receivable is not yet appropriate, to which the correspondence is related.*

G.8 *Contractors should seek to identify and recover mistaken or conditional primary payments made in MSP situations in accordance with CMS instructions. CMS instructions would include MSP regulations, CMS manuals, program memorandums, joint signature memorandums, CMS contractor letters, etc.*

G.9 *Contractors should have processes and procedures in place to ensure accuracy and compliancy and timely implementation of CMS directives. Contractors should have quality assurance measures in place to ensure proper referral of debt to treasury as well as to ensure accuracy in the implementation of any CMS directive.*

H **Administrative**

***H*.1** *All e*mployees 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.

***H*.2** Procurements *are* awarded and administered in accordance with the Medicare Agreement/Contract, CMS regulations, CMS general instructions and the Federal Acquisition Regulation.

***H*.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.

***H*.4** Medicare management structure provides for efficient contract performance and is consistent with business practices.

***H*.5** Records must be retained according to guidelines established by CMS and other Federal agencies.

***H*.6** *Controls provide reasonable assurance that certain regularly scheduled processes required to support the Medicare Contractor's continuity of operations in the event of a catastrophic loss of relevant, distinguishable Medicare business unit facilities are performed as scheduled.*

I **Provider Audit and Reimbursement**

***I*.1** *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 that provider payment files are updated in a timely and accurate manner. Adjustments to interim payments should be made to insure that payments approximate final program liability within established ranges. Payment records are adequately protected.*

***I*.2** Information received by *the contractor from* CMS or obtained from other sources *regarding* new provider*s*, change of ownership for an existing provider, terminat*ion of* a provider, or a change of intermediary are identified, recorded, and processed in a timely and accurate manner.

***I*.3** *Provider Cost Reports are properly submitted and accepted in accordance with CMS's general instructions, appropriate program policies and instructions are followed in situations where the provider did not file a cost report and cost report submission information is timely and properly forwarded to the proper CMS system.*

***I*.4** *Desk review procedures and performance are documented and are sufficient to obtain an accurate review of the submitted cost report. Documentation should be established and maintained to identify provider situations requiring a limited desk review, a full desk review or desk review steps required for focus reviews.*

***I*.5** *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.*

***I*.6** *Inputs to mandated reports and systems regarding provider audit, settlement, and reimbursement performance (STAR, CASR, etc.) are complete, accurate and in compliance with program instructions. Documentation supporting reports and inputs should be maintained.*

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

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

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

***I*.10** Information *necessary* to update the Provider Statistical and Reimbursement Report (PSRR) *in a timely, accurate and complete manner,* is obtained and reconciled with paid claims files *and related reports are distributed to providers.*

***I*.11** *An internal quality control process has been established and is functioning in accordance with CMS instructions to ensure that audit work (field 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.*

I.12 *Cost reports are scoped and selected for field audit, focused review, or settled without audit based on audit plans that adhere to CMS guidelines and instructions.*

I.13 *Communications of audit programs, desk review, CMS audit and reimbursement policies, and other audit related instructions are timely and accurately communicated to all appropriate audit staff.*

I.14 *The contractor's audit staff maintains its necessary knowledge and skills by completing continuing education and training (CET) required by CMS and GAS instructions, and documentation is maintained to support compliance by each staff member.*

I.15 *Supervisory reviews are conducted and the policies and procedures for these reviews are communicated to all supervisors in accordance with CMS program instructions.*

I.16 *All cost reports that require referral to the OIG are referred in accordance with CMS and contractor instructions.*

I.17 *Contractor has processes and procedures in place to document that supervisor reviews were completed on all corrective action plans (CAPs) from the establishment of the CAPs to the implementation and validation of the CAPs.*

J **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 should 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-MC751A/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.

***J*.1** *Financial transactions are valid and approved by authorized personnel in accordance with management and CMS' policies.*

***J*.2** Recorded and processed transactions are *correctly* classified, maintained, summarized, reconciled, *and reported*. In addition, all transactions must be *properly* supported.

***J*.3** *S*egregation of duties exists within the areas of disbursement and collection (i.e., there should be separate authorization, record keeping, and custody).

***J*.4** Accounts receivable should exist *and* be *properly* valued and aged. *Accounts receivable* should be correctly recorded in the books/records of the contractor.

***J*.5** Contractor Financial Reports are *accurate, signed/certified by authorized individuals and presented timely to CMS in accordance with MIM Sections 1900 to 1960.21 and MCM Sections 4900 to 4960.14.*

***J*.6** Banking information relevant to Medicare processing is accurately stated and conforms to the tripartite agreement.

K **Debt *Referral***

K.1 *Procedures, to identify a debt eligible for referral for cross servicing and the Treasury Offset Program (TOP) in a timely manner, are documented and available for review. Reports supporting the timely review and identification are also available for review.*

K.2 *Intent to Refer letters for all eligible delinquent debt are sent in a timely manner in accordance with CMS instructions.*

K.3 *Responses to the Intent to Refer letter are handled timely and appropriate systems (Provider Overpayment Reporting (POR) system and the Physician and Supplier Overpayment Reporting (PSOR) system) are updated to reflect any changes to the eligibility status of the debt. Procedures are documented and are in place to process undeliverable letters.*

K.4 *Eligible delinquent debt is input to the DCS accurately and timely.*

K.5 *Recall/Adjustment Forms are prepared when there is a status change to debt that has been referred for cross servicing.*

K.6 *Contractor has processes and procedures in place to ensure that Collection Reconciliation Acknowledgement forms are prepared timely and accurately. Forms are tracked and maintained for audit verification purposes.*

K.7 *Treasury disputes are researched and resolved timely and procedures are followed to update the status of the debt.*

K.8 *Financial reporting of debts, including the reporting of debts referred and accurate exemptions of debts is in compliance with CMS instructions.*

L ***Non-MSP Debt Collection***

L.1 *Demand letters initiate the collection of a provider debt as well as inform the provider of the existence of the debt, their appeal rights with respect to the debt, and the ramifications if the debt is not paid or an agreement is not reached within a specified time period.*

L.2 *Supervisor in accordance with CMS instructions reviews extended Repayment Plans (ERP). This includes monitoring all approved ERPs, the complete financial analysis of the provider's application, and the referral to CMS when necessary.*

L.3 *Interest is applied correctly and timely in accordance with CMS instructions. When necessary, interest adjustments are calculated correctly and processed and applied in a timely manner.*

L.4 *Bankruptcy cases are handled in accordance with CMS instructions and instructions given by the Office of General Counsel (OGC). An audit trail of the overpayment must exist before and after the bankruptcy filing to ensure that Medicare's best interest can be represented by OGC.*

L.5 *Provider debt is collected timely, completely, and accurately with an appropriate audit trail of all collection activity and attempts of collection activity. This audit trail supports the amount of the provider debt that is reported on CMS systems and financial reports.*

L.6 *All appropriate entries to CMS' POR/PSOR and contractor internal systems are made timely and accurately and reconciled among the relevant CMS systems. Discrepancies are corrected and an audit trail is maintained.*

L.7 *Timely review and processing of all 838 Credit Balance Reports. Ensure that all reported credit balances are collected and properly processed in accordance with CMS instructions.*

M ***Provider Enrollment***

M.1 *Enroll providers/suppliers in the Medicare Program and issue provider numbers in accordance with CMS guidelines.*

M.2 *Enrollment applications are processed accurately and timely. This includes – but is not limited to - reviewing all names listed on the application against the OIG/MED exclusion list, GSA debarment list, FID, and HIPDB; verifying that the applicant is duly licensed or certified (carriers only); verifying the tax identification number of the applicant; verifying the validity of practice locations and "pay to" addresses, including a reviewing of the contractor's electronic funds transfer (EFT) operations. Documentation verifying that these tasks were performed must be in accordance with Section 25 of Chapter 10 of the PIM.*

M.3 *Provider enrollment files are kept in a secure environment in accordance with Section 24 of Chapter 10 of the PIM.*

M.4 *Reassignments of benefits are made in accordance with Section 3060 of the Medicare Carriers Manual (MCM) and Section 7 of Chapter 10 of the PIM. (Carriers only)*

M.5 *Billing arrangements are in accordance with Section 3060 of MCM (MIM Section 3488 for intermediaries)*

M.6 *The UPIN Registry is updated accurately and timely in accordance with Section 1005 of the MCM. (Carriers only)*

M.7 *Personnel are trained in all aspects of Provider Enrollment as instructed in the Program Integrity Manual Section 2.2.*

20.5 - Documentation and Work Papers - (Rev. 15, 02-07-03)

The Medicare contractor must document through its work papers the process it employed to support its internal control certification. *This documentation must include work papers so that a CMS reviewer can conclude that the Risk Assessment process as described in Section 20.1 follows or exceeds these guidelines, and that the Control Activities (Section 20.3) identified to support the high risk control objectives selected for review are current and clearly stated. Finally the CPIC documentation must demonstrate how the Testing Methods employed comply with the general parameters as described in Section 20.4 for the purpose of Control Activity validation.*

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 conclusion 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 should 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 should ensure that the working papers follow certain standards. As a whole, a good set of working papers should 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.

30.1 - Requirements - (Rev. 15, 02-07-03)

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 provides CMS with assurance that contractors are in compliance with the Federal Managers' Financial Integrity Act of 1982 (FMFIA) and Chief Financial Officers (CFO) 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 70) 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.

You are required to submit to CMS your CPIC, which includes a description of your risk assessment, certification statement, executive summary, and CPIC *Report of Material Weaknesses*, by October 15 each year.

We remind you 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, you are 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 organization.

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 organization 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. You are required to perform a yearly risk assessment, prior to conducting your reviews, to ensure that the most critical areas are evaluated. We 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. We expect that you will add to this list as you conduct your risk assessment.

When performing your yearly risk assessment, you are 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.

30.2 - Certification Statement - (Rev. 15, 02-07-03)

You are required to provide a certification statement to CMS pertaining to your internal controls. Listed below is a generic certification statement. This statement should 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.

Your 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, *N3-11-17*
Baltimore, MD 21244-1850

Dear Ms. Snyder:

As (Medicare Chief Financial Officer *and* Vice President for Medicare) of (contractor name), *we are* 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 (CFO) Act by incorporating internal control standards into my operations.

We are cognizant of the importance of internal controls. *We* 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, *we* have included an assessment and testing of the programmatic, administrative, and financial controls for the Medicare program operations.

In the enclosures to this letter, *we* 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.

If material weaknesses have been identified, use the following language: "Material weaknesses have been reported to you and the appropriate regional office. The respective Corrective Action Plans have been forwarded to your office."

If no material weaknesses were identified, use the following language: "No material weaknesses have been identified during our review, therefore no material weaknesses have been reported."

We have also included a description of our risk assessment analysis *and our* Certification Package for Internal Controls Report of Material *Weaknesses*. This letter and its attachments summarize the results of our review.

We 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.

Sincerely,

(Medicare Chief Financial Officer Signature)

(Vice President for Medicare Signature)

30.3 - Executive Summary - (Rev. 15, 02-07-03)

An executive summary should be included in your CPIC. This summary should 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.

I. The total number of material weaknesses reported in the Certification Package for Internal Controls Report of Material Weaknesses.

J. The total number of reportable conditions reported in the Certification Package for Internal Controls Report of Reportable Conditions.

Within this report, you are asked to identify reportable conditions and material weaknesses. **Keep in mind that while you are required to document, track, and correct problems identified as reportable conditions, no corrective action plan (CAP) is required.** With a material weakness, however, you are required to provide written notification, including a CAP, to your regional office within 45 calendar days of identifying the problem. Within that same time frame you are also required to send an electronic copy, 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. The CAPs will be

reviewed and approved by the appropriate business owner(s) within CMS. *Once CMS has been notified of these material weaknesses, Medicare contractors are assigned a CMS Finding Number to each material weakness, using the instructions in Attachment B and include them in your next CAP quarterly report.*

*Y*ou are required to include all CPIC material weakness CAPs on the Universal CAP report *submitted following your CPIC submission by October 30*. *Your Universal CAP report* 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 you 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 §30.8 below and examples of each have also been provided. In your CPIC Report of Material Weaknesses you must also identify the status of the CAP for each material weakness. An electronic version of the CPIC Report of Material Weaknesses must be sent to CMS at internalcontrols@cms.hhs.gov in Microsoft Excel 2000 or other compatible software program.

The CPIC represents an annual summary of your internal control environment for the current fiscal year as certified by your organization. *All findings that were identified in the current fiscal year shall be considered for inclusion in the CPIC submission. These findings should be disclosed as material weaknesses or reportable conditions if they had an impact on your internal control structure. You should consider findings that resulted from internal and external audits and reviews, such as GAO and OIG audits as well as CFO Act audits, consultant reviews, management control reviews, CPE engagements, and other similar activities.*

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. *SAS 70 exceptions will have two CMS finding numbers, one assigned by the CPA firm conducting the SAS 70, and the other assigned by the Medicare contractor for the CPIC submission. Both CMS finding numbers should be noted on the CPIC Report of Material Weaknesses and the Universal CAP report.*

Your 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, *N3-11-17*
Baltimore, MD 21244-1850

A copy should also be forwarded to your regional office. Also, an electronic copy of the documents included in your CPIC package (in a format compatible with Microsoft Office 2000) should be sent to internalcontrols@cms.hhs.gov. *The file names for all electronic files submitted, as part of your CPIC package should begin with the three or four letter abbreviation assigned to each Medicare contractor in Attachment B - CMS Finding Numbers. Additionally, in the subject line of your email submission, you must include the corporate name of the entity submitting the CPIC.*

30.4 - CPIC- Report of Material Weaknesses - (Rev. 15, 02-07-03)

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

1. CMS Finding Number *is* to be assigned *to each material weakness* by *the Medicare contractor* prior *to submission of the CPIC package.* The CMS Finding Numbers can be found in Attachment B - CMS Finding Numbers. *Note: The second section of the CMS finding number will identify the fiscal year that the CPIC will be submitted, i.e. for the CPIC due on October 15, 2003, all CPIC material weaknesses will be assigned "03" in the second position which is the year of the review within the CMS finding number. Additionally, all CPIC material weaknesses will be identified with a "C" in the third section of the CMS finding number. Material weaknesses should be numbered sequentially beginning with "001". Information related to each material weakness should be on only one row of the spreadsheet; the "wrap text" function in Excel should be utilized.*
2. The original source of the finding. *If the original source of the finding is a SAS 70 review you are required to note the corresponding CMS Finding Number assigned by the CPA firm conducting the SAS 70 review in addition to assigning the finding a new CMS finding number for submission of the CPIC Report of Material Weaknesses.*
3. The control objectives numbers impacted (from §20.2.1). *Each material weakness should have at least one control objective associated with it. However, a material weakness could have more than one control objective associated with it. If more than one control objective is impacted by the material weakness, the*

finding should be listed only once with multiple control objectives listed with it. Additionally, you need to prioritize the control objectives impacted by each finding and limit them to no more than five. Additionally, the current list of control objectives from Section 20.2.1 should be used (i.e., FY'03 control objective should be referenced for the FY'03 CPIC submission).

4. A summary of the material weakness.
5. The corrective action plan (CAP).
6. Target completion date for the CAP.
7. Actual completion date for the CAP (if completed).

The total number of material weaknesses reported should be included. Each material weakness should be reported once for this total count, even if there is more than one control objective impacted by the material weakness.

30.5 - CPIC- Report of Reportable Conditions - (Rev. 15, 02-07-03)

The CPIC Report of Reportable Conditions should 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 *including when the condition was observed and corrected (or the status if not corrected)*.

Each reportable condition should be numbered and the total number of reportable conditions reported should be included. Medicare contractors are required to prepare and maintain this report internally. It should be available for review by CMS central and/or regional office staff. The Report of Reportable Conditions SHOULD NOT be submitted as part of the annual CPIC submission.

30.6 - Definitions and Examples of Reportable Conditions and Material Weaknesses - (Rev. 15, 02-07-03)

Contractors are expected to identify Reportable Condition*s* and/or Material Weakness*es* 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 should* be submitted to CMS. You should, however, *internally document* 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.

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, you are required to provide a CAP, to your regional office within 30 calendar days of identifying the problem. Within that same time frame you are also 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.

40 - Corrective Action Plans - (Rev. 15, 02-07-03)

For fiscal year (FY) 1999, CMS received its first unqualified audit opinion on its financial statements. Since then, the goal has been to maintain that unqualified opinion. Therefore, CMS has continued to make financial management improvements that will improve internal controls over the corrective action plan (CAP) process. The annual Chief Financial Officer (CFO) audit as well as various other types of reviews has helped to identify operational weaknesses that limits CMS's ability to effectively manage the Medicare program. Correcting these findings is critical if we are to demonstrate our commitment to improving financial management and internal controls.

The CMS has established policies and procedures to ensure that the Medicare contractors have appropriate CAPs for addressing findings, exceptions or material weaknesses identified through a:

1. CFO financial or electronic data processing (EDP) *audits which may include network vulnerability assessment/security testing (NVA/ST)*;
2. Statement of Auditing Standards (SAS)-70 review;
3. Submission of a Certification Package of Internal Controls (CPIC);
4. Account receivable (AR) advisory review;
5. *HHS Office of Inspector General (OIG) Information Technology (IT) Controls Assessment;*
6. *Financial reviews conducted by the General Accounting Office (GAO);*
7. *CMS 1522 reviews.*

Administrative cost and provider audits conducted by the OIG are excluded from these procedures. *CAPs for other EDP and system security reviews or evaluations, including Medicare contractor initiated systems security annual compliance audits and penetration tests should not be included on the quarterly CAP report.* Additionally, CAPs for CPE findings should not be included on the quarterly CAP report. However, if a finding's original source was a CPE finding and the contractor's analysis determines it should be considered a material weakness, it must be reported on the CPIC Report of Material Weaknesses as part of the CPIC submission. Throughout the remainder of these instructions, the word "findings" will refer to various audit findings including exceptions and material weaknesses depending on the type of review performed.

A new Universal CAP Report, prepared in Microsoft Excel, will be used to report on all open CAPs for all fiscal years. There should only be one report submitted by Medicare contractors for all CAPs related to the findings listed above. Because of a character limitation within Excel, CAPs will need to be summarized. If there has been no change in a CAP since the previous report, simply list the current date along with a comment of "no change" in the Update/Status of CAP column.

40.1 - Submission, Review, and Approval of Corrective Action Plans (Rev. 15, 02-07-03)

Upon completion of any of the reviews noted above, with the exception of the CPIC, the Medicare contractor will receive a final report from the auditors or advisors noting all findings identified during their review. Within 45 days of the date of the report, the Medicare contractor is required to submit an initial CAP report, using the universal CAP format, that addresses all of the reported findings which is certified by the Vice President (VP) of Medicare Operations. *Initial CAPs should be submitted using the Universal CAP report format, which should include only initial CAPs for an individual review. For example initial CAPs for the CFO audit will be submitted separately from other CAPs previously submitted to CMS. After the initial submission, those CAPs should be merged onto the Universal CAP report containing all other CAPs previously submitted to CMS.*

The CMS will no longer send a letter to the contractors requesting the submission of a CAP; however, CMS will continue to request a CAP from the system maintainers. *For SAS 70 reviews, CAPs are required for exceptions noted in the opinion letter only, not those discussed in Section III.* The universal CAP report must also include corrective actions addressing findings identified in the annual CPIC, except when the finding's original source was a CPE finding.

If the auditors or advisors classify any finding as a "recommendation", the Medicare contractor *is required to track these recommendations internally and support their determinations by keeping all relevant documentation. Recommendations should not be included on your Universal CAP report.*

Similarly, if the auditors or advisors classify any finding as a "global finding", the Medicare contractor is required to provide a CAP that reports the status of any requests

submitted to system maintainers for system changes, program enhancements, or modifications needed or already implemented to correct system limitations and findings. The Medicare contractors must also include information regarding the priority of the request by the impacted user group and the contractor's efforts taken to get the programming request addressed by your systems maintainer.

A quarterly universal CAP report updating the status of the Medicare contractor's initial CAP is due within 30 days following the end of each quarter (i.e., January 30, April 30, July 30, and October 30). The quarterly universal CAP report should address all open findings, as well as continue to report information on all findings reported as completed by the Medicare contractor, until CMS sends the Medicare contractor a standard closeout letter indicating which findings are officially closed. After the Medicare contractor receives the closeout letter, they may discontinue reporting on those findings in future quarterly CAP submissions. Separate CAP reports are not required for findings identified in prior fiscal years. Instead, all findings, regardless of the year identified *or type of review*, should be included in the single universal CAP report.

To facilitate the timely submission of the CAP, CMS established an Internet e-mail address, CAPS@cms.hhs.gov Medicare contractors to electronically submit all universal CAP reports. Since Medicare contractors must consolidate all CAPs into one universal CAP report, Medicare contractors will no longer electronically submit SAS 70 or CPIC CAPs to the e-mail box, internalcontrols@cms.hhs.gov. Contractors are required to furnish *an electronic* copy of the *universal* CAP *report* to *their* CMS Consortium Administrator, Regional Administrator, Associate Regional Administrator for Financial Management, Consortium Contractor Management Officer, and the designated Regional Office CFO coordinator. Contractors are also required to submit a hard copy of the universal CAP report that has been certified by the VP of Medicare Operations to:

The Centers for Medicare & Medicaid Services
Attention: Chief Financial Officer
7500 Security Blvd, *N3-11-17*
Baltimore, MD 21244

The CMS will review each CAP report submission to determine if the Medicare contractor adequately addressed each finding. The CMS will respond to the contractor within 45 days either approving the CAP, rejecting the CAP or requesting a revised CAP for any finding that was not adequately addressed by annotating this information on the CAP. Quarterly updates will also be reviewed; however, CMS will not respond to the CAP unless the CAP indicates that the Medicare contractor is not making adequate progress on implementing the CAP or has made significant changes to target completion dates.

40.2 - Universal Corrective Action Plan (CAP) Report - (Rev. 15, 02-07-03)

The CMS has developed the universal CAP report to consolidate all CAPs, for the reviews noted above, which will simplify the process of submitting CAPs by Medicare contractors. The universal CAP report must include the items explained below using the format provided in Attachment A - Universal CAP Report. Findings should be grouped by type of review (i.e. CFO, SAS'70, receivable consulting, CPIC, etc.). *Be advised that due to the development of an internal CMS CAP Tracking System, Medicare contractors will only be allowed to update certain fields on the quarterly Universal CAP report. More detailed instructions will follow, as the system gets closer to implementation.*

CMS finding number - the finding number assigned by the auditor/reviewer *(or assigned by the Medicare contractor if it is a CPIC material weakness)* and noted in final reports to identify and track contractor findings. See Attachment B for the number methodology utilized by the auditors;

Repeat/Duplicate CMS Finding Numbers - Findings may be duplicated and reported in more than one type of review. If the findings are duplicated, provide all other CMS finding numbers from other reviews conducted noting the same finding. *Note: the Source of Finding column has been deleted and replaced with the Repeat/Duplicate CMS Finding Number column;*

Control objective(s) impacted (completed only for SAS'70 and CPIC type reviews) - the control objective number(s) impacted by an identified finding. More than one control objective may be impacted for each finding *but you need to prioritize and limit the control objectives impacted to no more than five*;

Exception/finding/material weakness - a detailed description of the exception (SAS 70 *opinion letter only*) or finding (CFO audits, etc.) as identified by the auditor/reviewer in their final report or the material weakness as reported in the CPIC;

Responsible individual name - *the name of a central individual that can provide information on the resolution of the CAP and is responsible for ensuring that the finding is resolved. This field can only include one name;*

Responsible individual email - *the email address of a central individual that can provide information on the resolution of the CAP and is responsible for ensuring that the finding is resolved. This field can only include one email address;*

Responsible individual phone number - *the phone number of a central individual that can provide information on the resolution of the CAP and is responsible for ensuring that the finding is resolved. This field can only include one phone number;*

Corrective action procedure(s) - the detailed actions that the contractor will take or has taken to resolve the finding. *If the procedures have more than one step, all steps must be included in one cell. Additionally, if the steps have multiple target and actual completion dates, include these in the Update/status of CAP column;*

Target completion date - the date the contractor *expects the final step of the* corrective action procedure to be fully implemented. *This field must include only one date with no text*;

Actual completion date - the date *all steps of the* corrective action procedure *are* considered to be complete and the finding has been resolved by the contractor. *This field must include only one date with no text*; and

Update/status of CAP - subsequent actions taken by the contractor to implement the initial CAP.

Attachment A - Universal CAP Report - (Rev. 15, 02-07-03)

The contractor should download Attachment A, the Universal CAP Report, as an Excel spreadsheet and add their data accordingly, without making changes to the format. Additionally, this electronic file should be labeled Quarterly CAP Report, should be identified using the contractor abbreviations found in Attachment B, and should include the submission date. For example, Blue Cross and Blue Shield of Arizona would name this file "ARZ Quarterly CAP Report 103002.xls".

View in pdf format

View and/or retain Excel file

Attachment B - CMS Finding Numbers - (Rev. 15, 02-07-03)

The CMS Finding Numbers 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 listed below.

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

C. The next *one digit is a letter* to identify the type of review. Choose one only out of the *eight* in the following list:

- *R* - Accounts Receivable review,
- C - CPIC,
- E - CFO EDP review,
- F - CFO Financial review,
- S - SAS 70,

- *O - OIG reviews,*
- *G - GAO reviews,*
- *P - CMS 1522 reviews, and*
- *V – CFO related NVA/ST*

D. The last *three* digits are *three* numbers assigned to each individual finding (beginning with *0*01, *0*02, *0*03, etc.). For example, for material weaknesses reported in a Certification Package for Internal Controls (CPIC) for FY 2003, the CMS Finding Numbers for AdminaStar Federal, Inc. would be ASF-03-C-*0*01, ASF-03-C-*0*02, ASF-03-C-*0*03, etc.

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