Medicare Financial Manual
Chapter 7 - Internal Control Requirements

Table of Contents
(Rev. 34, 02-06-04)

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

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

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

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

This section provides a brief description of the legislative requirements that drive the efforts of the Center for Medicare & Medicaid Services (CMS) to strengthen Medicare contractor internal controls. The Federal Managers' Financial Integrity Act of 1982 (FMFIA) establishes internal control requirements that must be met by CMS and impact the Medicare contractors. For CMS to meet the spirit of FMFIA, Medicare contractors must demonstrate they comply with the FMFIA guidelines

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

Congress passed the FMFIA in 1982 after a series of scandals and previous initiatives by the government to eliminate fraud, waste, and abuse. The act requires that internal accounting and administrative controls of each executive agency be established in accordance with the standards prescribed by the Comptroller General. Under FMFIA, the Office of Management and Budget (OMB) establishes guidelines for agencies to evaluate their systems of internal accounting and administrative control to determine such systems' compliance with the standards established by the Comptroller General.
Under the prescribed standards of the FMFIA agencies must provide reasonable assurance to the President and Congress on an annual basis that:
Obligations and costs are in compliance with applicable law.

Funds, property, and other assets are safeguarded against waste, loss, unauthorized use, or misappropriation.
Revenues and expenditures applicable to agency operations are properly recorded and accounted for to permit the preparation of accounts, reliable financial and statistical reports, and to maintain accountability over the assets.

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.

10.1.3 - Chief Financial Act of 1990 (CFO) - (Rev. 7, 08-30-02)

The CFO Act of 1990 was created in part to gain financial control of government operations. The CFO Act establishes a leadership structure, provides for long range planning, requires audited financial statements, and strengthens accountability reporting. The aim of the CFO Act is to improve financial management systems and information. The CFO Act also requires the development and maintenance of agency financial management systems that comply with:
Applicable accounting principles, standards, and requirements;
Internal control standards; and
Requirements of OMB, the Department of the Treasury, and others.

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

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

operating structure and environment. By giving agencies the discretion to determine which tools to use in arriving at the annual assurance statement to the President and Congress, the Circular represents an important step toward a streamlined management control program that incorporates the reinvention principles of the Administration.

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

The Federal Managers' Financial Integrity Act of 1982 (FMFIA) requires the General Accounting Office (GAO) to issue standards for internal control in government. GAO's "Standards for Internal Controls in the Federal Government" as updated in November 1999. The standards provide the overall framework for establishing and maintaining internal control and for identifying and addressing major performance and management challenges as well as areas of greatest risk of fraud, waste, abuse, and mismanagement. These are the internal control standards that CMS and its Medicare contractors are being held to.

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

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

Internal controls are the checks and balances that ensure that operational objectives are carried out as planned in the most effective and efficient manner possible. We should not look upon these controls as separate specialized systems, but as integral parts of each system that management uses to accomplish the objectives of the Medicare program. In this regard Internal Controls are not just financial tools that safeguard assets, but are tools that are of vital importance to day-to-day programmatic and administrative operations as well. Internal control should be the first thought in CMS's oversight process. That is, can we be sure that there are adequate internal controls in place and operating effectively for the process we are evaluating?

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

- Effectiveness and efficiency of operations;
- Reliability of financial reporting; and
- Compliance with applicable laws and regulations

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

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

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

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

B - Are effected by people

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

C - Provide reasonable assurance, not absolute assurance

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

Examples of limitations are:

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

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

c. **Management Override -** high-level personnel may be able to override prescribed policies and procedures for personal gain or advantage. This should not be confused with management intervention, which represents management actions to depart from prescribed policies and procedures for legitimate purposes;

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

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

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

A. Control environment;

B. Risk assessment;

C. Control activities;

D. Information and communication; and

E. Monitoring.

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

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

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

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

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

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

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

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

Risk assessment is the identification and analysis of relevant risks to the achievement of established objectives. A key factor in the consideration of an internal control structure is the importance and risk associated with a program and its associated cost effectiveness. When determining whether a particular control objective should be established, the risk of failure and the potential affect must be considered along with the cost of establishing the control.

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

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

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

A. Examples of Control Activities:

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

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

B. Control Activities Specific to Information Systems:

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

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

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

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

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

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

Internal control systems need to be monitored. Monitoring is a process that assesses the quality of the system's performance over time. Internal control should generally be designed to assure that ongoing monitoring occurs in the course of normal operations. This is accomplished through ongoing monitoring activities, separate evaluations or a

combination of the two. Ongoing monitoring includes regular management and supervisory activities, and other action personnel take in performing their duties. The scope and frequency of separate evaluations will depend primarily on an assessment of risks and the effectiveness of ongoing monitoring procedures. Internal control deficiencies should be reported upstream, with serious matters reported to executive management.

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

20.1 - Risk Assessment

(Rev 34, 02-06-04)

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. *Examples of sufficient documentation are meeting agendas, meeting notes or minutes, emails, etc. The sufficient documentation should be readily available for CMS review.* The Medicare contractor is encouraged to exceed the risk assessment approach provided based on its unique operations. *The risk assessment process shall at a minimum include the following and shall be submitted as part of the CPIC package:*

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 *auditable* unit. Limit the list to the primary activities designed to achieve the goals and objectives of the *auditable* unit.

Step 2 - Prioritize Risk and Exposure Factors

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.

Step 3 – Create a Matrix to Illustrate the Prioritization of Risk and Exposure Factors

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.

NOTE: *CMS considers system security to be a critical risk area. Therefore, we require that you include control objective A.1 in your CPIC each year. All Medicare contractors are required to certify their system security compliance. You must verify that a system's security features meet CMS Core Security Requirements as defined by the Business Partners Systems Security Manual (BPSSM). Medicare contractors must write a few paragraphs to self-certify that their organization has successfully completed a security self-assessment of their Medicare IT systems and associated software in accordance with the terms of their Medicare Agreement/Contract. See §3.3 of the Business Partners System Security Manual, which can be found at www.cms.hhs.gov/it/security for more details.*

20.2 - Internal Control Objectives -

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

1. Operations - relating to effective and efficient use of the organization's resources.
2. Financial - relating to preparation of reliable financial statements.
3. Compliance - relating to the organization's compliance with applicable laws and regulations.

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

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

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

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

20.2.1 - FY 2004 Medicare Control Objectives

(Rev. 34, 02-06-2004)

Control Number	Control Objective: Controls provide reasonable assurance that…

Controls provide reasonable assurance that…

A	**Information Systems**
A.1	An entity-wide security program has been documented, approved *and monitored by management in accordance with the CMS Business Partners Systems Security Manual (BPSSM).*
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 *are monitored and investigated.*
A.7	Medicare application and related systems software development and maintenance activities are authorized, documented, tested, and approved.
A.8	Adequate segregation to 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 *in accordance with the guidance provided within the BPSSM.*
A.11	*A Risk Assessment and a systems security plan has been documented, approved, and monitored by management in accordance with the CMS Risk Assessment and Systems Security Plan Methodologies.*
A.12	*An Information Technology Systems Contingency Plan has been documented, approved, and monitored by management in accordance with the guidance provided within the BPSSM.*
A.13	*An IT Systems Contingency Plan (which includes a Disaster Recovery*

Plan) is reviewed, tested, and updated as required by the BPSSM.

B **Claims Processing**

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

B .2 *Claims, adjustments and other d*ata scheduled for processing is valid and errors are rejected. *An audit trail exists for each claim edit.*

B .3 *Paper and electronic c*laims are *paid* in accordance with CMS *payment* guidelines *for both amount and timeliness*.

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

B .5 Claim payments are properly calculated and duplicate claims are identified prior to payment. *Fee schedules are properly received, logged, and changed in the system and monitored.*

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. *Identified inappropriate practices are properly documented, communicated to management, and reported to CMS.*

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. *Part B* claims processed by Fiscal Intermediaries *(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)**

If BI work has been transitioned to the PSCs and you are no longer responsible for this function, do not include it in your CPIC submission.

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 syste*m*.

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 *Contractor must use the Program Integrity Manual (PIM) and Budget Performance Request (BPR) guidelines, data analysis and prior year Medical Review (MR) results, and Comprehensive Error Rate Testing (CERT) findings to develop the combined MR/Local Provider Education Training (LPET) Strategy document. The MR/LPET Strategy document must address site-specific problems, prioritization of problems, funding, and workload and must be targeted toward the goal of reducing the error rate.*

F .2 *Contractor must perform data analysis continuously throughout the fiscal year (FY) to identify potential problems such as aberrant billing practices, potential areas of over utilization, and changes in patterns of care over time. Data from a variety of sources must be used for data analysis. [Examples of data sources could include: 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), Medicare contractors with similar geographic or size qualities, OIG reports, GAO reports, enrollment data, fraud alerts, and other available sources.]*

F .3 *Contractor must utilize the Progressive Corrective Action (PCA) process, in accordance with PIM and CMS instructions, to drive medical review activity (i.e., data analysis, claims review, policy development and education).*

F .4 *Contractor must develop, revise, and maintain Local Policies in the appropriate format (see www.cms.hhs.gov/coverage) in accordance with PIM guidelines.*

F .5 *Contractor must implement edits developed as a result of data analysis in detecting inappropriate claims. The effectiveness of each edit must be analyzed and measured by tracking the denial rate, appeals reversal rate, dollar return on the cost of operationalizing the edit, and billing behavior correction. Edits must be modified or deleted when they are determined to no longer be effective.*

F .6 *Contractor must budget and perform the MR and LPET workloads throughout the FY as established in the MR/LPET strategy.*

F .7 *Contractor must report workload volume and associated costs, calculated in accordance with the approved cost allocation plan, accurately and timely in the monthly MR IER reports. Variances*

between budgeted and actual volume and costs (5 percent or greater) must be adequately addressed by ensuring appropriate strategy revisions and budget adjustments are made and submitted to the RO in accordance with PIM instructions.

F .8 *Contractor must be capable of identifying the status of each individual claim subjected to medical review at any time and all claims must be closed timely in accordance with PIM instructions.*

F .9 *Contractor must effectively comply with all of the MR/LPET requirements of the Joint Operating Agreement with the PSCs.*

F .10 *The Contractor LPET program must utilize efficient and effective multifaceted educational activities utilizing various formats, conducted throughout the fiscal year, to address existing program vulnerabilities or emerging problems identified during the MR process.*

F .11 *Contractor must utilize post-LPET intervention data analysis findings to evaluate LPET training and intervention effectiveness.*

F .12 *Contractor must implement and utilize a Provider Tracking System (PTS) to track all provider contacts and ensure effective follow-up in accordance with PIM guidelines.*

F .13 *Contractor must ensure that an adequate internal network has been established to facilitate the sharing of information between Medical Review and other business functions such as Benefit Integrity/PSC, Appeals, Audits, PCOM, and inquiries. Appropriate collaborative actions must be taken based on the information shared.*

F .14 *Contractor must apply quality assurance processes to all elements of the MR/LPET Strategy and to all aspects of program management, data analysis, edit effectiveness, problem identification, and claim adjudication.*

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 Audit 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 clai*m. 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 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 employees 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***

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 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 providers, change of ownership for an existing

provider, termination 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. *A*ppropriate program policies and instructions are followed in situations where the provider did not file a cost report. *C*ost report submission information is timely and properly forwarded to the proper CMS *Systems*.

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

I .5 Final settlement *of the cost report is issued to the providers, which includes all adjustments to the cost report,* and accurate and timely Notices of Program Reimbursement (NPR) including all related documentation.

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. *J*urisdictional 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. *R*elated 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 *The c*ontractor 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 Debt – Currently Not Collectible (CMS –C751*

A/B)

- Status of Medicare Secondary Payer Accounts Receivable (CMS-M751A/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 and *reconciled*. In addition, all transactions must be properly supported.

J .3 Segregation 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 *Accounts payables should exist and be properly valued. Accounts payable should be correctly recorded in the books/ records of the contractor.*

J .6 Contractor Financial Reports are accurate, signed/certified by authorized individuals and presented timely to CMS in accordance with Chapter 5 of the Medicare Financial Management Manual.

J.7 Banking information relevant to Medicare processing is accurately stated

and conforms to the tripartite agreement.

K **Debt Referral *(MSP and Non-MSP)***

K.1 Procedures, to identify a debt eligible for referral for cross servicing and Treasury Offset Program (TOP) in a timely manner are documented and available for review. Documentation to support the timely review and identification are also available for review. (MSP CR 2145, Non-MSP CR 1683 and CR 2436).

K.2 Intent to refer letters for eligible debt are sent in a timely manner in accordance with CMS instructions. (MSP CR 2145, Non-MSP CR 1683 and CR 2436).

K.3 Responses to the Intent to refer letter are handled timely according to CMS instructions regarding correspondence from the debtor. Appropriate systems (i.e. POR/PSOR) as well as internal systems are updated timely in accordance with CMS instructions to reflect any changes to the eligibility status of the debt. Procedures are documented and in place to handle undeliverable letters, per CR 2145 and the DCS User Guide. (and IOM, Chapter 4, Section 70, when published.)

K.4 Eligible delinquent debt is input to the DCS accurately to ensure data agrees with data in contractor internal system and the POR/PSOR system, if applicable and timely in accordance with CMS established timeframes to meet debt referral goal.

K.5 Recall/Adjustment Forms are prepared when there is a change to a debt that has been referred for cross servicing, per CMS instructions. Procedures to track these forms for completion are in place and are being followed. (See instructions on the Recall/Adjustment Form).

K.6 Contractor has processes and procedures in place to ensure that the Collection Reconciliation Acknowledgement forms are prepared in accordance with CMS instructions.

K.7 Treasury Action forms for MSP debts are researched and resolved timely in accordance with CMS instructions (CR 2145, CR 2749) and appropriate actions are taken in accordance with CMS instructions.

K.8 Financial reporting of debts, including the reporting of debts eligible and ineligible for cross servicing are reported accurately and timely in accordance with CMS instructions (CR 2641).

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. *In addition to the content of the demand letter, the demand letter shall be issued, printed and mailed timely.*

L.2 *All Extended Repayment Plans (ERP) shall be analyzed for approval or denial. A supervisor, in accordance with CMS instructions, reviews all ERPs*. 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.*

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 *as found in Program Memorandum Change Request 2810.*

L.8 *All overpayments, regardless of where they are determined, (Claims Processing, Program Safeguard Contractor, Benefits Integrity, Overpayments, Audit and Reimbursement…) are demanded and collection efforts are pursued.*

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 §25, Chapter 10 of the PI*M*.

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

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

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

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

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

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

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

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

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

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

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

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

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

Testing and evaluating the policies and procedures generally consists of five steps:

Step 1: Select the policy or procedure to be tested

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

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

Step 2: Select test methods

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

1. Document Analysis: a test method used to determine if the policies and procedures are effective by reviewing existing records, completed forms, or other documentation.
2. Observations: a test method used to determine if the policies and procedures are working by watching the performance of that control objective. Observation is often used when the reviewer wants to test how the control objective works for an entire cycle for the function or activity. In this case, the observer watches the performance of all of the steps and observes all involved personnel. For example, a reviewer may observe what happens to a check from the time it is received to

the time it is entered into the log and secured in the office safe. A reviewer would record who took which steps, and which controls were used.

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

Step 3: Determine how much testing is needed

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

1. Breadth: Breadth of the sample assures that the testing covers all bases and is a representative cross section of the universe being tested. This will provide confidence that the sample will allow lead to a conclusion about the situation as a whole.
2. Size: Size is the number of items sampled. The size should be large enough to allow a conclusion that the findings have not happened by chance and provide confidence in the conclusion. However the size of the sample should not be so large that testing becomes too costly. Selecting the size of the sample consider:
    a. Experience: Reducing the size of the sample when controls have operated satisfactorily in the past and no major changes in system/personnel have occurred.
    b. Margin of Error: Increase the size of the sample when only a small margin of error is acceptable.
    c. Importance: Increase the size of the sample when an important resource is at stake.
    d. Type: Increase the size of the sample when the control to be tested requires judgment calls. Decrease the size of the sample when the control is routine.

Step 4: Plan data collection

The sampling plan gives an idea of the "who, what, when, and where" aspect of the tests to be conducted. A data collection plan can be used to determine how the test results will be recorded. The accurate recording of test results is an extremely important part of the test documentation. Planning data collection prior to beginning the testing can be very

helpful to ensure the information collected will provide conclusive data from which to evaluate the controls.

Step 5: Conduct the tests

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

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

20.5 - Documentation and Work Papers - (Rev. 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 - Certification Package for Internal Controls (CPIC) - (Rev. 7, 08-30-02)

30.1 – Requirements

(Rev 34, 02-06-04)

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. *This should include a matrix to illustrate the prioritization of risk and exposure factors and a narrative or flowchart that outlines the risk assessment process (*see §*20.1 for more details regarding the risk assessment). Your CPIC should also include the* 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.

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.

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. *Each finding identified as an internal control deficiency should be categorized as either a material weakness or a reportable condition based upon the definitions provided in §30.8.* 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.

A hardcopy of your CPIC package should be sent to the Office of Financial Management at the address listed below:

Mr. Tim Hill
Chief Financial Officer
Office of Financial Management
Attn: Accounting Management Group, N3-11-17
Centers for Medicare & Medicaid Services
7500 Security Boulevard, N3-11-17
Baltimore, MD 21244-1850

An electronic version of *all documents submitted as part of your CPIC submission* must be sent to CMS at internalcontrols@cms.hhs.gov *as Microsoft Excel or Word files. Electronic copies should also be sent to your Associate Regional Administrator for Financial Management, the Chief Financial Officer (if you are in the Western Consortium), your CFO/SAS 70 Coordinator, your CCMO and Contract Manager.* 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 *§40.3.* Additionally, in the subject line of your email submission, you must include the corporate name of the entity submitting the CPIC.

30.2 - Certification Statement
(Rev 34, 02-06-04)

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:*

Mr. Tim Hill
Chief Financial Officer
Office of Financial Management
Attn: Accounting Management Group, N3-11-17
Centers for Medicare & Medicaid Services
7500 Security Boulevard, N3-11-17
Baltimore, MD 21244-1850

Dear M*r. Hill*:

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) A list of the functional areas selected for review;

D) The *specific* time period during which *each of* the reviews were conducted;

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

F) The location and custodian of the working papers for the review*;*

G) The name, telephone number, and email address of the contact person who can explain the risk assessment process, the certification review, the results, and the status of any corrective action plans;

H) The total number of material weaknesses reported in the Certification Package for Internal Controls Report of Material Weaknesses; and

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

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 34, 02-06-04)

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. *A list of the* functional areas selected for review;

D. The *specific* time period during which *each of* the reviews were conducted;

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

F. The location and custodian of the working papers;

G. 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*;*

H. The total number of material weaknesses reported in the Certification Package for Internal Controls Report of Material Weaknesses*; and*

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

Within *the executive summary*, you are asked to identify *the total number of* 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.**

30.4 - CPIC- Report of Material Weaknesses
(Rev 34, 02-06-04)

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 Section 40.3. 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, 200*4*, all CPIC material weaknesses will be assigned "0*4*" 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. *Repeat/Duplicate Finding Number(s). In order to classify a repeat or duplicate finding, the finding must be exactly the same as a finding identified in another audit or review. Similar findings should not be classified as a repeat or duplicate finding.*

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. *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 §20.2.1 should be used (i.e., *FY 2004* control objective should be referenced for the *FY 2004* 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).

8. *The date the material weakness was identified.*

9. *The date the initial CAP was submitted to CMS as instructed in §30.7.*

10. 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. *If the original source is a CPE review, you must include the report date and site location of the review.*

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.

All material weaknesses reported in your CPIC report of material weaknesses must be reported on an Initial CAP Report and be received by November 30 even if you have already submitted the initial CAP at an earlier date in the year. A blank Initial CAP report must be used to submit the CAPS and must be downloaded from Section 40.5. After the initial submission, all CPIC material weaknesses must be included in the next quarterly CAP report due January 30 for the quarter ending December 31. ***All material weaknesses reported on your CPIC Report of Material Weaknesses must be reported on your Quarterly CAP Report, regardless of the original source of the finding****. If a finding's original source was a CPE review and the contractor's analysis determines it should be considered a material weakness and impacts your internal control environment, it must be reported on the CPIC Report of Material Weaknesses and included as part of the CPIC submission.*

All SAS 70 exceptions identified during the fiscal year must be reported as a Material Weakness in your CPIC submission, 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 Quarterly 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 Quarterly CAP report.*

NOTE: *If you have received a CAP closing letter on a material weakness that you are reporting, include a copy of the closing letter as part of the CPIC submission. Even if a CAP closing letter has been received, if the material weakness existed at any time during the fiscal year, it must be reported on your CPIC Report of Material Weaknesses.*

30.5 - CPIC- Report of Reportable Conditions

(Rev 34, 02-06-04)

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 §*20.2.1*).

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 listed and the total number of reportable conditions 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.

NOTE: *When reportable conditions are identified, you must evaluate internal corrective actions for each of the reportable conditions and you should correct each issue.*

30.6 - Definitions and Examples of Reportable Conditions and Material Weaknesses

(Rev 34, 02-06-04)

Contractors are expected to identify Reportable Conditions and/or Material Weaknesses 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).

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).

With a material weakness, you are required to provide a CAP, to *the CAP workgroup at CAPS@cms.hhs.gov, to the Internal Control team at internalcontrols@cms.hhs.gov, and also to your Associate Regional Administrator for Financial Management or CFO if you are in the Western Consortium,* within *45* calendar days of identifying the problem. *Also, you must* provide a hard copy of the CAP to the Office of Financial Management at the address listed in §30.3.

30.7 - Material Weaknesses Identified during the Fiscal Year

(Rev 34, 02-06-04)

The evaluation of your internal control environment should be an ongoing process throughout the fiscal year. It should not be a once-a-year event, which occurs prior to submission of your annual CPIC. During the fiscal year, if material weaknesses are identified, you are required to send an electronic copy, via E-mail, to CAPS@cms.hhs.gov and internalcontrols@cms.hhs.gov., within that same time frame you are required to provide written notification, utilizing the initial CAP Report form available under §40.5, to your Associate Regional Administrator for Financial Management or CFO if you are in the Western Consortium, within 45 calendar days of identifying the problem.

After the submission of your CPIC report on or before October 15, you are required to resubmit all material weaknesses identified during the year using the Initial CAP Report found in §40.5.

Also, you must provide a hard copy of the initial CAP to the Office of Financial Management at the address listed in §*30.1. Medicare contractors must assign a CMS Finding Number to each material weakness, using the instructions in §40.3. The first material weakness identified during the year should be assigned finding number XYZ-04-C-001 and each subsequent material weakness identified should be numbered sequentially. Each finding must then be included in the next quarterly CAP report due to CMS. All material weaknesses identified during the year must be included in your CPIC submission due on October 15.*

40 - Corrective Action Plans
(Rev 34, 02-06-04)

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 *the following reviews:*

1. CFO financial or electronic data processing (EDP) *audits related to annual CFO Financial Statement audits (*which may include network vulnerability assessment/security testing (NVA/ST);

2. Statement *on* Auditing Standards *No. 70 (SAS 70) review (including novations);*

3. Submission of a Certification Package of Internal Controls (CPIC);

4. Account receivable (AR) 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 workgroup reviews; and*

8. *CMS CPIC workgroup 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.

All material weaknesses reported in your annual CPIC must be reported on your Quarterly CAP Report, regardless of the original source of the finding. If a finding's original source was a CPE review, and the contractor's analysis determines it should be considered a material weakness, *and it impacts your internal control environment*, 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 *deficiencies, exceptions,* and material weaknesses depending on the type of review performed.

A *Quarterly* 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 *each* Medicare contractor for all CAPs related to the findings listed above. *Each CAP must be a summary of the procedure to correct the finding.* If there has been no change in a *specific* 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 34, 02-06-04)

Upon completion of any of the reviews noted *in §40,* 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 *calendar* days of the date of the report, the Medicare contractor is required to submit an initial CAP report, using the Initial CAP *report* format from §40.5. *The initial CAP report must address* all of the reported findings *assigned a finding number and be* certified by the Vice President (VP) of Medicare Operations. *In the case of SAS 70 reports, initial CAPS are due within 45*

calendar days of the date of receipt of the final report. The SAS 70 reports are dated with the final day of fieldwork, not the date of issuance. Initial CAPs should be submitted using the Initial 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 Quarterly CAP report containing all other CAPs previously submitted to CMS. Your Quarterly CAP report may already include CAPs from the SAS 70, CFO audit, Accounts Receivable review, or other financial management reviews. All Initial and Quarterly CAP reports must be submitted electronically to *CAPS@cms.hhs.gov as* well as to *your Associate Regional Administrator for Financial Management, the Chief Financial Officer (if you are in the Western Consortium), your CFO/SAS 70 Coordinator, your CCMO, and Contract Manager.*

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.

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 Initial 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* CAP report updating the status of the Medicare contractor's initial CAP is due within 30 days following the end of each quarter. *Therefore, all electronic and hardcopy CAP reports should be received by CMS on or before January 30, April 30, July 30, and October 30 annually*. The *Quarterly* 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, *the CAP must be removed from the Quarterly CAP report.* 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 *Quarterly* CAP report.

To facilitate the timely submission of the *Initial and Quarterly* CAP *reports*, CMS established an Internet e-mail address, CAPS@cms.hhs.gov *for* Medicare contractors to

electronically submit all CAP reports. Since Medicare contractors must consolidate all CAPs into one 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 CAP report to their CMS Associate Regional Administrator for Financial Management, Consortium Contractor Management Officer, and the designated Regional Office CFO coordinator. Contractors are also required to submit *the original* hard copy of all *initial and quarterly* CAP reports that has been *signed* by the VP of Medicare Operations to:

The Centers for Medicare & Medicaid Services
Attention: Accounting Management Group, N3-11-17
7500 Security Blvd
Baltimore, MD 21244

The CMS will review *all Initial* CAP Reports to determine if the Medicare contractor adequately addressed each finding. The CMS will respond to the contractor either approving the CAP, rejecting the CAP, or requesting a revised CAP *or additional information* 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.

Medicare Contractors must maintain and have available for review backup documentation to support implementation of each CAP. This will facilitate the validation of CAPS by CMS or its agents.

40.2 - Corrective Action Plan (CAP) Reports (Rev 34, 02-06-04)

The *Initial or* Quarterly CAP report must include the items explained below using the format provided in §40.4 and §40.5. Findings should be grouped by type of review (i.e. CFO, SAS 70, *accounts receivable*, 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 CAP report. More detailed instructions will follow, as the system gets closer to implementation.

Definitions of CAP report data fields:

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 §40.3 for the number methodology utilized by the auditors.

Repeat/Duplicate CMS Finding Numbers – *If a finding/exception is repeated or duplicated in subsequent years or reported in more than one type of review, provide all other CMS finding numbers for that issue. Repeat or duplicate finding numbers listed for a particular finding must be an identical issue, not a related or similar issue.*

Findings with a Repeat/duplicate finding number shall be listed twice on the CAP report, once with each of the CMS finding numbers listed as the primary CMS finding number. If a finding has more than one repeat/duplicate finding number is must be listed as many times as there are associated finding numbers. This will mean that the CMS finding numbers for all open findings will be listed once in the primary CMS finding number column (the first column on the left on the CAP report). Additionally, the text of the original finding must be listed with the corresponding CMS finding number. For example, if one auditor words the finding differently than another, the text from the original report should be listed with its assigned finding number.

Control objective(s) impacted ***- Required only for SAS 70 exceptions and CPIC material weaknesses type of reviews.*** *This represents 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 - A*n* individual that can provide information on the resolution of the CAP and is responsible for ensuring that the finding is resolved.

Responsible individual email - The email address of *an* individual that can provide information on the resolution of the CAP and is responsible for ensuring that the finding is resolved.

Responsible individual phone number - The phone number of *an* individual that can provide information on the resolution of the CAP and is responsible for ensuring that the finding is resolved..

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.

Actual completion date - The date all steps of the corrective action procedure are considered to be complete and the contractor has resolved the finding

Update/status of CAP - Subsequent actions taken by the *Medicare c*ontractor to implement the initial CAP. *If there are more than five control objectives impacted, add them to this field. If there has been no change in a specific CAP since the previous report, simply list the current date along with a comment of "no change" in the Update/Status of CAP column.*

40.3 - CMS Finding Numbers
(Rev 34, 02-06-04)

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 from the following list:*

- R - Accounts Receivable review;
- C – CPIC *(your annual self certification package);*
- E - CFO EDP review;
- F - CFO Financial review;
- S – *Statement on Auditing Standards No. 70* (SAS 70);
- O - OIG reviews *(HHS Office of Inspector General (Information Technology) controls assessment;*
- G - GAO reviews *(financial reviews);*
- P - CMS 1522 *workgroup* reviews;
- V - CFO related NVA/ST
- *N – SAS 70 Novation, and*
- *M – CMS CPIC workgroup reviews.*

D. The last three digits are three numbers assigned sequentially 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 2004, the

CMS Finding Numbers for AdminaStar Federal, Inc. would be ASF-04-C-0 01, ASF-04-C-0 02, ASF-04-C-0 03, etc.

Contractor *Abbreviations*

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
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
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
United Government Services	UGS
Wisconsin Physicians Service Insurance Corporation	WPS

40.4 - Initial CAP Report

(Rev 34, 02-06-04)

All initial CAPs should be reported on the Initial CAP Report downloaded from this section. After this initial submission, CAPs should be merged onto the Quarterly CAP report in §40.5. All CAPs, for the reviews noted in §40, should be consolidated onto one Quarterly CAP Report. However, if you have findings for an affiliated data center or system maintainer, these findings must be reported on a separate CAP report, and not with reported contractor findings. Specifically, if the three or four letter abbreviation listed in §40.3 is not the same for all findings, a separate CAP report is required for each set of findings associated with that abbreviation code.

The contractor should download the Initial CAP Report, as an Excel spreadsheet and add their data following the steps below. The format of the spreadsheet should not be altered. Additionally, this electronic file should be labeled Initial CAP Report, should be

identified using the contractor abbreviations found in §40.3, and should include the submission date. For example, Blue Cross and Blue Shield of Arizona would name this file "ARZ Initial CAP Report 103002.xls".

View in pdf format

View and/or retain Excel file

40.5 - Quarterly CAP Report
(Rev 34, 02-06-04)

The contractor should download the Quarterly 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 §40.3, 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

40.6 – Entering Data into the Initial or Quarterly CAP Report

(Rev 34, 02-06-04)

Overview

CMS developed a spreadsheet application form to assist the contractors in entering data quickly and easily into the CAP report. The application features drop down lists, reducing the amount of manually entered data, and has the ability to detect errors as each data element of information is entered. It also provides specific help features to assist in correcting detected errors.

Launching the Spreadsheet Application

Download the Initial CAP report from §40.4. Locate the file and double click on it to start Microsoft Excel and load the spreadsheet application. Or manually open Excel and use the 'File' – Open menu command to select and open the file, which also loads the spreadsheet application.

*When opening the file, a **Dialogue Box** pops up. You must click on **Enable Macros**. This will allow the spreadsheet to function properly and provide assistance in entering data and check for errors.*

Entering Data

The first ten rows of the Initial or Quarterly CAP report are considered to be the header of the spreadsheet and contain eight data elements (rows 2 through 9). The data elements are ***Contractor Name****,* ***Contractor Number, Date of Submission, Contact Person Name****,* ***Contact Person Email****,* ***Contact Person Phone Number, Vice President (VP) for Medicare Operations Name,*** *and* ***VP for Medicare Operations Signature.***

Header data elements:

Contractor Name *– Position your cursor in cell B2 of the spreadsheet. A dialogue box will appear. Click on the* ***[arrow]*** *on the right side of the CMS Contractor Name dialogue box to invoke the* ***Pull Down Menu*** *of contractor names.* ***Select*** *the appropriate name. After the name is selected, the cursor will automatically move to the next field:* ***Contactor Number.***

Contractor Number *– Enter your contractor number(s). The number cannot exceed 5 digits and if less than 5 digits are entered, leading zeros will automatically be entered. If more than 1 contractor number is entered, separate the numbers with a comma (,). Maintainers and Data Centers are not required to enter a contractor number, thus this field should be left blank. A flyover help box is provided to ensure the proper format is followed.*

Date of Submission *– Enter the date in the format of mm/dd/yyyy that the CAP report will be submitted to CMS. A flyover help box is provided to ensure the proper format is followed.*

Contact Person's Name *– Enter the first and last name of the person that may be contacted regarding any questions on the submission of the CAP report.*

Contact Person's Email*– Enter the email address of the contact person. The email address must be properly formatted with an '@' sign.*

Contact Person's Phone # - *Enter the contact person's phone number (i.e., 410-786-5555, ext.123456). The phone number may have an extension of up to 6 digits. A flyover help box is provided to ensure that the proper format is followed.*

VP for Medicare Operations Name *– Enter the first and last name of the Vice President of Medicare Operations.*

VP for Medicare Operations Signature *– A signature is not required to be completed on the electronic version of the spreadsheet; however, an original signed hard copy must be sent to CMS for each Initial CAP Report submission and all Quarterly CAP Report updates.*

NOTE: If incomplete information is entered or is not entered in the proper format, an error message will be displayed after each data entry indicating that the information is

invalid. The application will not allow you to continue until all errors in the header are corrected. Also, you may use the function 7 (F7) key to enable spell check.

Row 11 *provides the name of each column in the Detail section of the spreadsheet. The cells in this row may not be changed.*

Proceed to cell A12 to begin to enter data in the Detail section of the spreadsheet.

To enter data, click the ***Edit Data*** *button in the header section.*

A dialogue box containing the ***'CMS CAP Data Input' form*** *will appear to allow information to be entered in the appropriate data fields. See Figure 1. All edits must be performed in this input form. Edits performed directly into a cell when not in this form cannot be saved.*

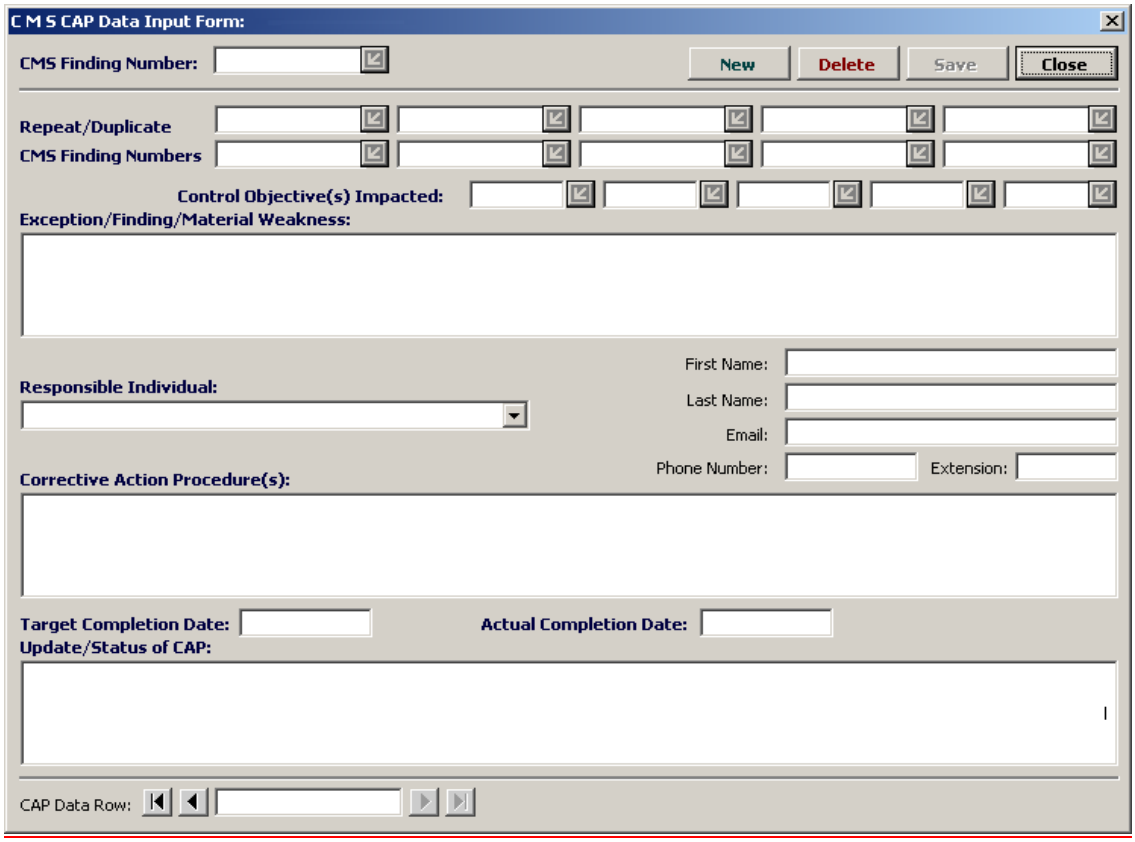

Figure 1: CMS CAP Data Input Form

Click on the ***[arrow]*** *to the right of the CMS finding number to open the next dialogue box containing the components of the CMS finding number. All components are required.*

CMS Finding Number components:

Contractor abbreviation *– The abbreviation will automatically be populated based on the* ***Contractor Name*** *entered in row 2 of the Header and as a result, will be grayed out. In order to change the abbreviation, the* ***Contractor Name*** *will have to be changed in the Header.*

NOTE: Since the contractor abbreviation will always link to the contractor name, Initial and Quarterly CAP reports can no longer combine findings that originated at your contractor location, your data center and/or those applicable to your maintainer system in one report. Separate reports using the spreadsheet application form must be completed for contractor, data center, and maintainer findings.

Year of Review *– Enter the last 2 digits of the applicable fiscal year (FY) that the review was conducted.*

Type of Review *– Click on the* ***[arrow]*** *on the right side of the Type of Review dialogue box to invoke the* ***Pull Down Menu*** *of review types.* ***Select*** *the review applicable to the reported finding.*

Sequential Numbering of Finding *– Click on the up or down* ***[arrows]*** *to the right side of the Sequential Numbering of Finding dialogue box to enter the finding number as reported by the auditors in their final report.*

When all components have been entered, click on the ***Save &Close*** *button. Click the* ***Clear*** *button to delete entered data if corrections are necessary. After corrections are completed, click on the* ***Save &Close*** *button.*

Use the ***tab key*** *or the* ***mouse*** *pointer to move to the next box, which is the* ***Repeat/Duplicate Finding Number****. If appropriate, click on the first* ***[arrow]*** *on the right side of the Repeat/Duplicate Finding Number to open the next dialogue box containing the components of the first Repeat/Duplicate Finding Number. Click subsequent* ***[arrows]*** *to enter additional repeat findings. The application allows a total of ten repeat/duplicate finding numbers to be entered.*

When all components of the ***Repeat/Duplicate Finding Number*** *have been entered, click on the* ***Save &Close*** *button. Click the* ***Clear*** *button to delete entered data if corrections are necessary. After corrections are completed, click on the* ***Save &Close*** *button.*

Use the ***tab key*** *or the* ***mouse*** *pointer to move to the next cell, which is the* ***Control Objective(s) Impacted****. If the* ***Type of Review*** *entered in the* ***CMS Finding Number*** *dialogue box was either C for Certification Package for Internal Control submissions, N for Novation SAS-70 reviews, or S for Statement on Auditing Standards No. 70 reviews, this field will be activated and control objectives need to be entered. All other* ***Types of Reviews*** *will disable this field and as a result, will be grayed out.*

Click on the ***[arrow]*** *on the right side of the Control Objective(s) Impacted dialogue box to open the Control Objectives Impacted selection box. Based on the FY entered as part*

*of the **CMS Finding Number**, the Control Objective Impacted selection screen will provide a **Pull Down Menu** of the control objectives effective in that FY. **Select** the appropriate control objective from the list.*

*After each control objective has been entered, click on the **Save &Close** button. Click the **Clear** button to delete entered data if corrections are necessary. After corrections are completed, click on the **Save &Close** button. Repeat outlined steps until all applicable control objectives have been entered. The application allows a maximum of five control objectives to be entered. If more than 5 control objectives are impacted for a given finding, add the additional control objectives impacted to the Update/Status of CAP portion of the spreadsheet.*

NOTE: If more than one control objective has been entered and deletions are necessary, you must click the Clear button and delete the objectives in the reverse order of entry. For example, the last control objective entered must be the first control objective deleted.

*Use the **tab key** or the **mouse** pointer to move to the next cell, which is the **Exception/Finding/Material Weakness** box in the Data Input Form. Enter text exactly as it appears in the auditor's final report. Do not paraphase. This field is limited to 1024 characters. Any additional information will be truncated. This is a required field.*

*Continue to use the **tab key** or the **mouse** pointer to move to the next few cells, which provide information on the **Responsible Individual** of the finding. Enter the first and last name of the **Responsible Individual**, their email address which must be properly formatted with an '@' sign, and their phone number in the format of xxx-xxx-xxxx and must not include parenthesis (i.e. 410-786-5555, ext.123456). The phone number may have an extension of up to 6 digits. Only one name, email address and phone number may be entered. These are required fields.*

*After the information is first entered into the individual fields, the information will be merged and displayed in a drop down list under the **Responsible Individual** title on the left of the screen. This information can then be used for subsequent CAPs without reentering the details.*

*The next box contains the **Corrective Action Procedures**. Enter the procedures that have or will be implemented to address the finding. This field is limited to 1024 characters. Any additional information will be truncated. This is a required field.*

*Press the **tab key** or the **mouse** printer to the **Target Completion Date** entry area. Enter the date that the finding is expected to be resolved using the format mm/dd/yyyy. This is a required field that must be completed for all findings and only allows one date with no text. If a finding is considered to be 'global', enter 02/22/2222. This date will act as an indicator to CMS that the finding is global and assist in easily identifying all findings as such.*

Enter an Actual Completion Date using the format mm/dd/yyyy to indicate when the CAP was implemented. This field must include only one date with no text. If the CAP has not been completed, leave this field blank.

*The last field is the **Update/Status** field. Use this field to provide updates to corrective action procedures or to indicate that no changes have been made since the last reporting cycle. If a notation is made indicating that a CAP is complete, you **must** ensure that an **Actual Completion Date** has been provided. This field is limited to 1024 characters. Any additional information will be truncated. This is a required field for the Quarterly CAP report.*

*Once you have filled in all the data fields, press the **Save** button on the top right hand corner. If you have failed to properly enter data in any of the fields, an error message should have already been displayed to indicate the fields where invalid data was entered. Therefore, all errors should have been corrected prior to saving the information.*

*Once the information is saved, which is indicated by the **Save** button being grayed out, you may either press the **Close** button or the **New** button. If you press the **Close** button, you will be returned to the spreadsheet application form. The data entered into the **Data Input Form** will now appear in the Excel spreadsheet. However, you may press the **New** button to remain in the **Data Input Form** and continue to enter additional findings.*

NOTE: We recommend that entries be saved after completing the Data Input Form for each finding to prevent the loss of any data.

Editing Existing CAP Data

*On the bottom left of the CMS CAP Data Input Form, there is a control bar (CAP Data Row) that lets you scroll through the completed rows while remaining in the **Data Input Form**. By clicking on the left or right arrows, you can scroll through the entries and make any changes that are needed. **Remember, you must press the Save button after any changes are made.***

*The application does not allow you to edit any data unless you are in the **Data Input Form**. If you try to manually enter or edit any information directly in the spreadsheet, the changes will not save because the data is protected. If changes are needed to existing data, position the cursor in any field in the row where the change is needed and click on the **Edit Data** button in the **Data Input Form.***

Saving Files

*To save the completed spreadsheet application form, press the **Save As** button at the top of the form. This button automatically creates a file name that incorporates user and date information that allows for easy tracking of spreadsheets and their different versions.*

The format for the file includes: Contractor Abbreviation, Report Name and Date (i.e. AHS Quarterly CAP Report 123101.xls). Please do not change the recommended file name that the application creates.