Program Memorandum Intermediaries/Carriers

Department of Health and Human Services (DHHS)
HEALTH CARE FINANCING ADMINISTRATION (HCFA)

Transmittal AB-01-77 **Date: MAY 14, 2001**

CHANGE REQUEST 1652

SUBJECT: The Certification Package for Internal Controls for Fiscal Year (FY) Ending September 30, 2001

This memorandum provides instructions for the Medicare intermediaries and carriers for conducting internal control reviews and for preparing FY 2001 certification packages and related materials. The key requirements and deadlines are summarized below in question and answer format.

1. Why do I have to prepare a Certification Package for Internal Controls?

The Certification Package for Internal Controls (CPIC) is essential to the audit of HCFA's financial statements by the Office of Inspector General (OIG) and to provide HCFA with knowledge and assurance that the contractors are complying with HCFA instructions and directions. By October 15, 2001, you are expected to certify your compliance with the Federal Managers' Financial Integrity Act (FMFIA) and Chief Financial Officers (CFO) Act by incorporating internal control standards into your operations. These standards are specified in the General Accounting Office's (GAO) "Standards for Internal Control in the Federal Government" as revised November 1999.

Reviews by OIG and GAO continue to identify problems with documentation and substantiation of the financial data essential for HCFA's preparation of its financial statements. All contractors have previously been made aware of their responsibilities to maintain accurate accounting records with supporting documentation, and to perform a reconciliation of all account balances. This expectation continues to remain a priority to HCFA for FY 2001.

In addition, by signing this certification, you are in compliance with the requirements of §3.3 of the Business Partners Systems Security Manual (HCFA-Pub 84).

2. What is required of me?

You are required to submit to HCFA your CPIC, which includes your risk assessment, certification statement, executive summary, and CPIC Reports of Material Weakness(es) and Reportable Condition(s), by October 15, 2001.

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 workpapers, you are required to document the respective policies and procedures for each control objective reviewed. These policies and procedures should be in writing, be updated to reflect any changes in operations, and be operating effectively and efficiently within your organization.

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

3. What is required in the risk assessment?

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, as Exhibit 4, a list of control objectives. These 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 HCFA-sponsored SAS-70 reviews. Any of these efforts could impact the conduct of 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.

NOTE: HCFA considers financial management to be a critical risk area. Therefore, we strongly suggest you include the financial management control objectives in your internal control certification review. (See sections C.3, E, F, and G in Exhibit 4.) If you believe, based upon your risk assessment that you should review other areas, you must document this in your CPIC.

4. What is required in the certification statement?

You are required to provide a certification statement to HCFA pertaining to your internal controls. Exhibit 5 contains a generic FY 2001 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, 2001.

5. What is required in the Executive Summary?

An Executive Summary should be included in your CPIC. This summary should provide, at a minimum:

a. The contractor identification numbers;
b. Geographical locations for which the certification applies;
c. The functional areas selected for review;
d. The time period during which the reviews were conducted;
e. A brief summary of the review results, time estimate for when any deficiency will be corrected, or a statement that it will be corrected;
f. The name and title of the person(s) who conducted the review;
g. The location and custodian of the working papers; and
h. The name, telephone number, and E-mail address of a contact person who can explain the risk assessment process, the certification review, the results, and the status of any corrective action plans.

6. What is required in the CPIC Reports of Material Weakness(es) and Reportable Condition(s)?

Within these reports, you are asked to identify reportable conditions and material weaknesses. Keep in mind that while you are required to document, track, and correct problems identified as reportable conditions, no Corrective Action Plan (CAP) is required. **With a material weakness, however, you are required to provide written notification, as well as a CAP, to your regional office within 30 calendar days of identifying the problem.** The CAPs will be reviewed and approved by the appropriate business owner(s) within HCFA. Within that same time frame you are also required to send an electronic copy, via E-mail, to internalcontrols@hcfa.gov and provide a hard copy of the CAP to the Office of Financial Management at the address listed on the following page.

After HCFA has completed its review and approval process, you will be required to include all current CPIC material weakness CAPs into an Internal Control quarterly CAP report. This quarterly report already includes CAPs from the SAS-70 reviews. The Internal Control quarterly report will be submitted electronically to the e-mail address listed above.

Note that you must reference the control number that corresponds to the control objective affected by the material weakness or reportable condition when filling out the CPIC Reports. (See Exhibits 1 and 2.) Each finding should be categorized as either a material weakness or a reportable condition. These terms have been defined and are included as Exhibit 3. An example of each has also been provided. In your CPIC Reports of Material Weakness(es) and Reportable Condition(s) you must also identify the status of the Corrective Action Plan (CAP) for each material weakness. An electronic version of this spreadsheet must be sent to HCFA in Microsoft Excel 97 or other compatible software program. Submit your electronically prepared CPIC to internalcontrols@hcfa.gov.

For the current CPIC, all SAS-70 exceptions identified during the fiscal year must be reflected in your CPIC report. The CPIC represents an annual summary of your internal control environment for the current FY as certified by your organization. Each exception should be classified as a material weakness. There is no need to duplicate the SAS-70 exception(s) already identified in the Internal Control quarterly CAP report.

7. Where do I send my CPIC package?

Your original CPIC package should be sent to HCFA's Office of Financial Management at the address listed below. A hard copy should also be forwarded to your regional office.

Ms. A. Michelle Snyder
Director
Office of Financial Management
Attn: Division of Risk Management
HCFA
7500 Security Boulevard, C3-01-24
Baltimore, MD 21244-1850

Also, an electronic copy of the documents included in your CPIC package (in a format compatible with Microsoft Office 97) should be sent to internalcontrols@hcfa.gov by October 15, 2001.

8. What about next year's CPIC?

Note that the control objectives are in the process of being updated for the 2002 CPIC. As we add new control objectives, we will simply add them within the appropriate category and assign each a new control number. In addition, we intend to provide guidance on the supporting documentation for your CPIC including your risk assessment and proper documentation of your policies and procedures. HCFA intends that the certification process will continue on a yearly basis and that it will be updated to reflect new or changed processes.

Attachments

The *effective date* for this Program Memorandum (PM) is October 1, 2000.

The *implementation date* for this PM is October 15, 2001.

These instructions should be implemented within your current operating budget.

This PM supersedes Transmittal AB-00-75 issued on August 18, 2000.

This PM may be discarded after May 14, 2002

If you have any questions, contact Patty Gould on (410) 786-6441 or William Karantzalis on (410) 786-3361.

Exhibit 1

	Certification Package for Internal Controls (CPIC)				
	Report of Material Weakness(es)				
MATERIAL WEAKNESS(ES)					
Control Number (as listed on Exhibit 4 FY 2001 Control Objectives)	Material Weakness	Status of Corrective Action Plan (CAP)			
NOTE: Prepare this form in Microsoft Excel 97 or a compatible software program.					

Exhibit 2

	Certification Package for Internal Controls (CPIC)				
	Report of Reportable Condition(s)				
REPORTABLE CONDITION(S)					
Control Number (as listed on Exhibit 4 FY 2001 Control Objectives)	Reportable Condition				
NOTE: Prepare this form in Microsoft Excel 97 or a compatible software program.					

Exhibit 3

Definitions and Examples of Reportable Condition(s) and Material Weakness(es)

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

A **REPORTABLE CONDITION** exists when a contractor's internal controls are adequate and reasonable assurance can be provided that the intent of the control objective is met, but problems requiring correction have been identified during the review. It is necessary for contractors to track and correct the problem, but no Corrective Action Plan (CAP) need be submitted to the Health Care Financing Administration (HCFA). Contractors should, however, inform HCFA when the condition was observed and corrected (or the status if not corrected), and include information on any dollar impact on the Medicare Trust Funds.

EXAMPLES:

1. Access controls are in place within the data centers; however, during the review it was found that particular employee passwords were openly displayed. (Control Objective 8- Establish physical and technical access controls to prevent or detect unauthorized access.)

2. While controls are in place, isolated incidents occurred where some supporting documentation for the HCFA 1522 report could not be located. (Control Objective 111- The contractor must provide HCFA with Contractor Financial Reports that are properly accumulated and accurately represent their financial data within mandated timeframes. In addition, the contractor must properly review the documentation/reports and have documentation to support each line item.)

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

EXAMPLES:

1. No controls are in place for access to data. Employees within certain data centers were found to share the same password. (Control Objective 8- Establish physical and technical access controls to prevent or detect unauthorized access.)

2. Formal processes for developing supporting documentation for value of outstanding Medicare payment checks for inclusion in HCFA 1522 report were not implemented and related documentation could not be located to support estimates used for the period reviewed. (Control Objective 111-The contractor must provide HCFA with Contractor Financial Reports that are properly accumulated and accurately represent their financial data within mandated timeframes. In addition, the contractor must properly review the documentation/reports and have documentation to support each line item.)

Exhibit 4

FY 2001 Control Objectives

Control Number	Control Objectives	
	A.	**Medicare Protocol Information Systems Objectives**
	A.1	***Entity-wide Security Program***
1	**A.1.a**	Periodically assesses risks.
2	**A.1.b**	Document an entity-wide security program plan.
3	**A.1.c**	Establish a security management structure and clearly assign security responsibilities.
4	**A.1.d**	Implement effective security related personnel policies.
5	**A.1.e**	Monitor the security program's effectiveness
	A.2	***Access Controls***
6	**A.2.a**	Classify information resources according to their criticality and sensitivity.
7	**A.2.b**	Maintain a current list of authorized users and their access authorization.
8	**A.2.c**	Establish physical and technical access controls to prevent or detect Unauthorized access.
9	**A.2.d**	Monitor access, investigate apparent security violations, and take appropriate remedial action.
	A.3	***Application software development and change control***
10	**A.3.a**	Ensure that processing features and program modifications are properly authorized.
11	**A.3.b**	Test and approve all new or newly revised software.
12	**A.3.c**	Control software libraries.
	A.4	***Segregation of Duties***
13	**A.4.a**	Segregate incompatible duties and establish related policies.
14	**A.4.b**	Establish access controls to enforce segregation of duties.
15	**A.4.c**	Control personnel activities through formal operating procedures, supervision, and review.
	A.5	***System Software***
16	**A.5.a**	Limit access to system software.
17	**A.5.b**	Monitors access to and use of system software.
18	**A.5.c**	Control system software changes.
	A.6	***Service Continuity***
19	**A.6.a**	Assess the criticality and sensitivity of computerized operations and identify supporting resources.
20	**A.6.b**	Take steps to prevent and minimize potential damages and interruption.
21	**A.6.c**	Develop and document a comprehensive contingency plan.
22	**A.6.d**	Periodically test the contingency plan and adjust as appropriate
	B	**Medicare Claims Processing Control Objectives**
	B.1	***Medicare Claims***
23	**B.1.a**	System capabilities and documentation are accessible in the Medicare claims processing system to track a claim from receipt to final resolution.
24	**B.1.b**	Procedures are established to ensure that the data scheduled for processing is valid and errors are rejected.
25	**B.1.c**	Controls and edits are in place to ensure claims are processed accurately and in a timely manner in accordance with HCFA guidelines.
26	**B.1.d**	Claims are reopened when necessary and in accordance with HCFA guidelines.
27	**B.1.e**	Claim payments are properly calculated and duplicate claims are identified prior to payment.
28	**B.1.f**	Claims are properly aged from the actual receipt date to the actual date of payment in compliance with legislative mandates.
29	**B.1.g**	Procedures are in place to train personnel to detect and deter fraudulent and abusive practices.
	B.2	***Appeals***
30	**B.2.a**	Medicare Part A reconsiderations and Part A reviews are processed based on HCFA instructions and completed within legislatively mandated time frames.
31	**B.2.b**	Medicare Part B reviews and hearings are appropriately logged and tracked to meet HCFA guidelines.
32	**B.2.c**	Medicare Part A reviews and hearings are processed based on HCFA Instructions and completed within HCFA's legislatively mandated time frames.
33	**B.2.d**	Medicare Part B reviews and hearings are processed based on HCFA Instructions and completed within legislatively mandated timeframes.
34	**B.2.e**	Policies are in place to ensure Administrative Law Judge (ALJ) cases are handled in compliance with legislatively mandated time frames.
	B.3	***Beneficiary/Provider Services***
35	**B.3.a**	Beneficiary and provider written and walk-in inquiries are handled accurately, appropriately, and in a timely manner.
36	**B.3.b**	Controls are in place to ensure telephone inquiries are answered timely, accurately, and appropriately.

37	**B.3.c**	Information, which is releasable in accordance with the Privacy Act, is handled properly.
38	**B.3.d**	A quality assurance program is in place to ensure Explanation of Medicare Benefits are properly generated (Part B only).
39	**B.3.e**	Methodologies are established as approved by HCFA to educate providers and beneficiaries in Medicare coverage, payment, and billing processes. Safeguards are in place to ensure Medicare information in provider bulletins is accurate and timely.
40	**B.3.f**	Safeguards are established in the Provider Enrollment Process to prevent sanctioned providers from receiving Medicare payment.
41	**B.3.g**	Enroll providers in the Medicare Participation Program and issue provider numbers in accordance with HCFA guidelines (Part B only).
	C	**Payment Safeguards**
	C.1	***Fraud and Abuse***
42	**C.1.a**	An independent fraud unit that is responsible for detecting and deterring potential fraud should be developed and maintained
43	**C.1.b**	Written procedures should exist for fraud department personnel to use for the detection and review of potential fraud situations.
44	**C.1.c**	Reactive and proactive techniques in the detection and development of potential fraud cases should be used especially in the area of data analysis
45	**C.1.d**	Procedures should exist to ensure appropriate safeguard and administrative actions are taken when fraud is suspected which should include suspension, recovery of overpayments, provider education, referral to OIG, and denials.
46	**C.1.e**	Management should support 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.
47	**C.1.f**	Written instructions should exist detailing procedures for interaction between the fraud unit and the following contractor units: Medical Review, Overpayment, Medicare Secondary Payer, Correspondence, Appeals, Provider Enrollment, Provider/Beneficiary Services and Audit.
48	**C.1.g**	All procedures established for handling fraud unit activities should be compliant with the current Medicare contract and all relevant Medicare Intermediary Manual (MIM) and Medicare Carrier Manual (MCM) sections, Budget Performance Requirements (BPR), Program Integrity Manual (PIM), and general instructions provided by HCFA.
49	**C.1.h**	Procedures should be in place and appropriate action taken for fraud unit personnel to educate other departments within Medicare on detecting and referring potential fraud situations. Procedures should exist to ensure that other areas within the contractor's organization are alerted to procedural and programmatic weaknesses.
50	**C.1.i**	All information gathered by and furnished to the fraud unit should be maintained in a secure environment, kept confidential and the privacy of all parties should be protected.
51	**C.1.j**	Ensure that information compiled for direct and indirect reporting to HCFA is clearly documented and can be traced to its original source.
52	**C.1.k**	Adequate controls should be in place within any automated Case Control system to ensure the data residing within this system is entered timely and is complete and accurate. Staff is proficient in use of the system.
53	**C.1.l**	Procedures should be in place to ensure that cases are appropriately identified and prioritized according to the guidelines established by HCFA.
54	**C.1.m**	Procedures should be in place to ensure that all inventory is properly controlled and monitored.
55	**C.1.n**	Procedures should be in place to ensure that all necessary documentation regarding actions taken and final disposition is properly executed and maintained.
56	**C.1.o**	Procedures should be in place to ensure that all requests for assistance from law enforcement agencies are responded to in a timely fashion.
57	**C.1.p**	Procedures should be in place to ensure that all report requirements are met in an accurate and timely manner.
58	**C.1.q**	Procedures should be in place to ensure that all notifications required by HCFA are performed in a timely fashion and in accordance with HCFA guidelines.
59	**C.1.r**	Procedures should be in place to ensure that all provider amounts due are properly recorded and all subsequent transactions are properly accounted for and recorded.
60	**C.1.s**	Procedures should be in place to ensure that all Restricted and National Medicare Fraud Alerts are appropriately handled.
61	**C.1.t**	Procedures should be in place to ensure that regular communication takes place with the OIG on referred or pending cases.
	C.2	***Medical Review***
	C.2.a	Data Analysis to Support Focused Medical Reviews (FMR)
62	**C.2.a.1**	Controls/procedures should be in place to conduct data analysis to identify baseline practice patterns, aberrances, potential areas of over utilization, patterns of non-covered care, and changes in utilization overtime (trends) by providers in aggregate, by specialty type or individually.
	C.2.b	Local Medical Review Policies (LMRPs)
63	**C.2.b.1**	When LMRPs are developed, ensure that the policies are comprehensive and accurate to the particular item or service(s) and are not in conflict with national policy.

	C.2.c	Prepayment Medical Review
64	**C.2.c.1**	Procedures should be in place to detect which HCFA-specified edit comparisons in the prepayment environment are producing the greatest savings or are the most frequently used.
65	**C.2.c.2**	Procedures should be in place so that when services are clearly non-covered, denials for those items/services are automated whenever possible.
66	**C.2.c.3**	Procedures should be in place to ensure necessary medical expertise is applied during the MR process.
67	**C.2.c.4**	Controls/procedures should be in place to ensure current MR/Progressive Corrective Action (PCA) instructions are used to verify that services billed are covered services, medically necessary, not excessive in nature, and are appropriately classified for payment and beneficiary liability purposes in accordance with current FY BPRs, as well as manual requirements.
	C.2.d	Post Payment Medical Review
68	**C.2.d.1**	A procedure should be in place to ensure thorough comprehensive post payment medical reviews and/or coverage compliance reviews fully comply with manual requirements.
69	**C.2.d.2**	Procedures should be in place to ensure the status of post payment cases that can be identified at any given point in time and are closed in a timely manner.
70	**C.2.d.3**	Controls/procedures should be in place to monitor the Medicare claims experience of all providers, and individual and group physicians/suppliers in your service area to acquire statistical data on them and their specialty groups.
71	**C.2.d.4**	Procedures should be in place to ensure providers are notified in a timely manner of any new or modified HCFA guidelines and are educated on appropriate billing practices.
72	**C.2.d.5**	Procedures should be in place to ensure provider contact resulting from the MR process is in compliance with the Medicare Intermediary Manual and/or Medicare Carrier Manual.
73	**C.2.d.6**	Assure all quality of care issues are referred to the Professional Review Organization, OIG, or the regional office (Health Standards and Quality).
74	**C.2.d.7**	Controls/procedures should be in place to identify suppliers who bill for services not ordered by a physician or items not properly certified by a physician.
75	**C.2.d.8**	Controls/procedures should be in place showing how management supports the internal networking and sharing of information on MR activities, potential fraud cases, audits, and MSP.
76	**C.2.d.9**	Procedures should be in place to ensure files contain proper documentation and are in compliance with HCFA, MIM, MCM, and PIM requirements.
	C.3	***Medicare Secondary Payer (MSP)***
77	**C.3.a**	Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure that MSP provisions are performed in accordance with current FY BPRs, as well as manual requirements.
78	**C.3.b**	Contractors should follow HCFA guidelines to ensure that claims involving multiple payers are processed correctly; i.e., when Medicare is primary, claims are paid as primary.
79	**C.3.c**	Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure compliance with the MSP provisions for the Internal Revenue Service/Social Security Administration/HCFA Data Match Recoveries project.
80	**C.3.d**	The contractor should document procedures that facilitate compliant treatment of MSP Data Match and Routine Recovery cases generated by the contractor when the third-party payer or the employer responds to any demand letter.
81	**C.3.e**	Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure that clear audit trails for MSP recoveries (receivables) are maintained
82	**C.3.f**	Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure the timely reporting of all required MSP reports.
83	**C.3.g**	Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure that correspondence is issued to the appropriate parties in cases where other party primary liability is suspected.
84	**C.3.h**	Contractors should seek recovery of mistaken or conditional primary payments made in MSP situations in accordance with all HCFA instructions.
	D	**Administrative Control Objectives**
85	**D.1**	Employees must comply with applicable laws and regulations regarding compliance issues, conflict of interest, and code of ethics. Program compliance education and training programs are in place to ensure that employees understand their responsibilities
86	**D.2**	Data being reported must be valid and free of errors before being submitted to HCFA or other reporting entities.
87	**D.3**	Reports shall be automated. If manual adjustments are made, appropriate documentation of the file must be made.
88	**D.4**	Procedures shall be in place to ensure that the integrity of the mailroom receipt date is maintained.

89	**D.5**	Incoming and outgoing mail, both electronic, and paper must be properly handled in accordance with published time frames, security guidelines, and in the most cost effective and efficient manner
90	**D.6**	Procurements must be awarded and administered in a consistent manner and in accordance with the Medicare contract and applicable FAR.
91	**D.7**	Appropriate levels of approval must be observed to ensure control and avoid potential legal issues.
92	**D.8**	Appropriate operating areas must ensure that instructions and critical tasks are implemented and maintained timely and accurately
93	**D.9**	Medicare management structure must be conducive to efficient contract performance and prudent business practices.
94	**D.10**	Records must be retained according to guidelines established by HCFA and other Federal agencies
95	**D.11**	Operations must have business continuity plans and the plans must be tested periodically.
	E.	**Provider Audit and Reimbursement**
96	**E.1**	All information received by HCFA or obtained by the contractor from other sources to establish a new provider, process a change of ownership for an existing provider, terminate a provider, or process a change of intermediary should be identified, recorded, and processed in a timely manner.
97	**E.2**	Interim payments to Medicare providers should be established in a timely manner, and monitored in accordance with HCFA general instructions. Adjustments to interim payments should be made to insure that payments approximate final program liability within established ranges. Provider payment files should be updated in a timely manner when adjustments are made, and should be adequately protected.
98	**E.3**	Systems should be established and maintained to insure that all Provider Cost Reports are submitted within the time frames stipulated by HCFA's general instructions. Once received, cost report information should be forwarded to the proper HCFA system. Controls should be established to trigger actions for cost reports that are not filed timely.
99	**E.4**	Desk Review activity should be properly scoped to obtain a fair and accurate review of reimbursed costs. Methods should be established and maintained to identify provider situations requiring either limited desk review or focused review. All tentative settlements based desk review activity should be made in a timely manner.
100	**E.5**	Audits of providers' records should be performed in accordance with HCFA instructions and in conjunction with Government Auditing Standards (GAS). The process should be managed through proper planning and budgeting. Objectives should be established to manage the process through proper working paper documentation, propose and communicate adjustments and to include the provider's responses. An internal quality control process (IQC) should be established to ensure the propriety of the audit process.
101	**E.6**	Control the settlement process by establishing procedures to include all adjustments to the cost report. Identify final program liability of the provider. Issue proper and timely Notices of Program Reimbursement (NPR) including all related documentation. All final settlements should be made in a timely manner.
102	**E.7**	Systems should be established to accurately identify, remit, or collect payments to/from providers. These systems should have the ability to track such transactions on an ongoing basis, and reconcile them with a provider's final program liability. All overpayments should be identified and collected in a timely manner. Files should be maintained and reconciled to identify outstanding provider receivables/payables according to HCFA instructions on financial reports. Proper communication among the provider, the Medicare Contractor, and HCFA should be maintained.
103	**E.8**	The Medicare contractor should establish and implement administrative procedures for the reopening of the Medicare cost report. All time frames regarding the conditions under which a cost report can be reopened should be included in the administrative procedures.
104	**E.9**	Procedures should be established and implemented for the processing of provider exception requests (such as End Stage Renal disease (ESRD) exceptions or Routine Cost Limit (RCL) exception requests, and other requests.)
105	**E.10**	The Medicare contractor must establish and implement administrative procedures for handling all provider appeals and adjustments. These controls should include both the Office of Hearings (OH) and Intermediary Appeals. The procedures should assure that all jurisdictional questions are addressed and all timeframes for submission are observed.
106	**E.11**	Procedures should be established and implemented to capture and update the Provider Statistical and Reimbursement Report (PSRR). Processes should be in place to distribute the report, as appropriate, to providers, and to internally reconcile the report with claims paid files.
107	**E.12**	Procedures should be established and implemented to assure that inputs to mandated reports regarding Provider Audit and Reimbursement performance (STAR, CASR, etc.) are accurate and in compliance with program instructions.
	F	**Financial Control Objectives**

		Transactions for Medicare benefit receivables, payables, expenses, and administrative costs must be recorded and reported timely and accurately, and financial reporting must be completed in accordance with HCFA 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 (HCFA 750A and HCFA 750B), ♦ Status of Accounts Receivable (HCFA 751A and HCFA 751B), ♦ Status of Accounts Receivable Medicare Secondary Payer (HCFA 751A-MSP and HCFA 751B-MSP), ♦ Reconcile to the Status of Accounts Receivable Regional Office (HCFA 751A-RO and HCFA 751B-RO), ♦ Reconcile to the Provider Overpayment Reporting (POR) System and the Physician Supplier Overpayment Reporting (PSOR) system. " Monthly Contractor Financial Report (HCFA 1522) and Contractor Draws on Letter of Credit (HCFA 1521), " Reconciliation of Cash Balances and Cash Receipts.
108	**F.1**	All transactions recorded and processed through the accounting system should be approved by appropriate individuals in accordance with management's criteria and should meet HCFA's policies.
109	**F.2**	All transactions and related processing activities must be supported by appropriate detailed records, which are properly classified, maintained, accurately summarized, and reconciled to account balances.
110	**F.3**	The contractor must provide for the segregation of duties for disbursement activities, collection activities, and activities related to assets
111	**F.4**	The contractor must provide HCFA with Contractor Financial Reports that are properly accumulated and accurately represent their financial data within mandated timeframes. In addition, the contractor must properly review the documentation/reports and have documentation to support each line item.
112	**F.5**	The contractor should have an individual sign and certify all reports, and where applicable, provide reasonable assurance that the information in the reports is accurate.
113	**F.6**	All accounts receivables should exist and be valued on an appropriate basis and should be correctly recorded in the books and records of the contractor.
114	**F.7**	All banking information received from the bank must be accurate and conform to the tripartite agreement.
115	**F.8**	Budget Performance Requirements must be met or an exception negotiated with HCFA.
	G	**Debt Collection**
116	**G.1**	Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure that provider debt collection provisions are performed in accordance with current FY BPRs, as well as manual requirements.
117	**G.2**	Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure that all provider amounts due are timely collected and that clear audit trails for debt recoveries (receivables) are maintained.
118	**G.3**	Procedures that are consistent with all HCFA applicable directives, regulations, etc., should be in place to ensure the proper recording and the timely reporting on the Provider Overpayment Reporting System and the Physician and Supplier Overpayment Report of all provider amounts due.
119	**G.4**	Controls/procedures should be in place showing how management supports the internal net working and sharing of information on debt collection activities
120	**G.5**	Procedures should be in place to ensure that all provider amounts due (account receivables) are properly controlled and monitored.
121	**G.6**	Procedures should be placed to ensure that all necessary documentation regarding debt collection actions taken and final disposition are properly executed and maintained.

Exhibit 5

Ms. A. Michelle Snyder
Director
Office of Financial Management
Health Care Financing Administration
7500 Security Boulevard, C3-01-24
Baltimore, MD 21244-1850

Dear Ms. Snyder:

As (Chief Executive Officer, Chief Financial Officer, or appropriate equivalent) of (contractor name), I am writing to provide certification of reasonable assurance that (contractor name) internal controls are in compliance with the Comptroller General's "Standards For Internal Controls in the Federal Government" as required by the Federal Managers' Financial Integrity Act and the Chief Financial Officers Act.

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

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

I also understand that officials from the Health Care Financing Administration, 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,

(Officials' Signature and Title)