

PREAUDIT
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999).

1

PREAUDIT

OBJECTIVES: (Overall objectives of the entire audit.)

1. To assure that Medicaid payment to the provider is materially correct for all cost reporting periods covered by the audit.
2. To assure that the final Medicaid cost report(s) is substantially in compliance with applicable law, regulations, instructions and procedures.
3. To obtain such information as may not otherwise be available to update fiscal intermediary files and data about the provider.

REFERENCES

MIM-4, §§4112.8, 4117 and 4118

PREAUDIT (Continued)
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

2

PREAUDIT INDEX

1. SCOPING/PLANNING THE AUDIT
2. COST REPORT QUESTIONNAIRE
3. SUPPORTING DOCUMENTATION
4. PERSONAL IMPAIRMENT STATEMENTS
5. NEW SERVICES
6. ITEMS TO LOOK FOR
7. POINTS FOR NEXT YEAR'S AUDIT
8. PROGRAM ABUSE

PREAUDIT (Continued)

3

HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

STEP	PROCEDURE DESCRIPTION	AUDITOR'S INITIALS AND DATE	WP REF
------	-----------------------	-----------------------------------	--------

PREAUDIT (Continued)
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

4

<u>STEP</u>	<u>PROCEDURE DESCRIPTION</u>	AUDITOR'S	<u>WP REF</u>
		INITIALS AND DATE	

SCOPING/PLANNING THE AUDIT

1. Prior to going on site, review the provider's filed cost report, the pertinent provider-submitted working papers included with the filed cost report, the cost report questionnaire (Form HCFA-339) with the required documentation, the desk review findings, the prior year audit adjustments, notes for auditors in the prior year's cost report audit, the intermediary correspondence files with the provider, and the audit scope and related audit program.

Note: Changes in either budget hours or audit steps to be performed must be justified and have proper approval from your supervisor. However, auditors should perform only those audit procedures that contribute to resolving problems identified in the audit scope or that have been discovered in the field and approved by management as additions to or replacements for existing procedures. Where it becomes apparent that an audit procedure is not productive and is not a good use of resources, the auditor should get approval to terminate the procedure.

COST REPORT QUESTIONNAIRE

2. Review all documentation requested with the provider cost report questionnaire, Form HCFA-339 (See PRM-II, §1100). This questionnaire is to be used as a survey of the provider's organization and operations. The questionnaire will give the auditor background on the changes in the hospital's operation and an understanding of the additional data needed to perform an effective audit.
 - A. Audited financial statements;
 - B. Copies of all loan agreements;
 - C. Copies of insurance policies and coverage;
 - D. Summary schedule of depreciable assets;
 - E. Copies of all lease agreements;
 - F. Copies of deferred compensation plans;
 - G. Copies of pension plans;
 - H. Copies of agreements with organization of nonpaid workers, if applicable;
- I. Costs attributable to services rendered by related organizations;

PREAUDIT (Continued)
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

5

STEP	PROCEDURE DESCRIPTION	AUDITOR'S INITIALS AND DATE	WP REF
------	-----------------------	-----------------------------------	--------

- J. All management or consultant contracts;
- K. Purchased service agreements, for example, therapy services; and
- L. All provider-based physician contracts and time allocation agreements showing the allocation of provider-based physicians' compensation between Part A (provider technical/administrative services, supervision of interns and residents), Part B (physician professional services) and nonreimbursable activities such as research.

SUPPORTING DOCUMENTATION

- 3. In advance of beginning fieldwork, send out the audit confirmation letter (MIM-4, §4112.9) and request the provider to make the following documents, where applicable to the scope of audit and if not already in the permanent file, available to the auditors upon arrival. Add to this list any additional documentation that you consider necessary for the completion of the audit (MIM-4, §4112.10, Exhibit II).
 - A. Board of Directors' minutes;
 - B. Working trial balance for the prior year with general ledger account groupings for the cost report (this should be in the prior year working paper file);
 - C. General Ledger account groupings for the current year's cost report;
 - D. General ledger;
 - E. Voucher register and invoices;
 - F. Journal entries;
 - G. Payroll registers (with IRS 941 forms and State and Federal Unemployment forms);
 - H. Hospital floor plan and supporting schedules indicating square footage by department;
 - I. Relevant financial auditors' workpapers (the provider will need to instruct the financial auditors to make these available for review);
 - J. Documentation to support Worksheet B-1 statistics as shown on the cost report (specify statistics for which documentation is requested);

PREAUDIT (Continued)
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

6

STEP	PROCEDURE DESCRIPTION	AUDITOR'S INITIALS AND DATE	WP REF
K.	Midnight census sheets and monthly patient day summaries;		
L.	Charge manual;		
M.	Chart of accounts;		
N.	Detailed bad debt listing and supporting documentation, including any collection policy changes not already in your permanent file and support for any bad debt recoveries;		
O.	Copies of any physician contracts;		
P.	Supporting detail for admissions and discharges by facility and provider number;		
Q.	Analysis of expense accounts (if prepared);		
R.	Foreign medical school graduate certificates, as applicable;		
S.	Copy of intern and resident program approvals and assignment (rotation) schedules;		
T.	Copy of nursing school and paramedical program approvals;		
U.	Medicaid logs, where settlement data is not obtained from the Unisys report;		
V.	IRS tax returns filed for a proprietary provider, or for a nonproprietary provider, the Form 990, Federal Information Return, and a copy of the IRS Exemption Certificate issued to nonprofit organizations;		
W.	Working papers supporting the cost report (that is, the detail utilized in the reconciliation of the working trial balance to the cost report and other documents required to be filed as support for the cost report (PRM-II));		
X.	Independent auditors' management letter, where deemed necessary (MIM-4, §4112.3);		
Y.	List of reviews done by internal auditors;		
Z.	Written agreements that exist between the organizations;		
AA.	Details relative to services or supplies furnished to the provider; and		

PREAUDIT (Continued)
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

7

<u>STEP</u>	<u>PROCEDURE DESCRIPTION</u>	<u>AUDITOR'S INITIALS AND DATE</u>	<u>WP REF</u>
-------------	------------------------------	--	---------------

BB. Method used to record costs from related organizations.

PERSONAL IMPAIRMENT STATEMENTS

4. Complete personal impairment statements for the auditors, supervisors and managers to the extent they are involved in the audit or the review of the audit.

NEW SERVICES

5. Determine if the provider restructured for a broader range of health care services. If necessary, expand the appropriate section of the audit program to include these areas for review, where the impact on Medicaid is significant.

ITEMS TO LOOK FOR BECAUSE OF COST
REIMBURSEMENT IMPLICATIONS

6.
 - A. Any subproviders, including excluded units, skilled nursing facility, home health agency, or other provider component;
 - B. Corporate Reorganizations (See Exhibit 1 - General); and
 - C. Research (usually a non-reimbursable cost center).
 - D. Working arrangements with providers or other entities (for example, joint ventures and affiliations).

POINTS FOR NEXT YEAR'S AUDIT

7. Throughout the current year audit, identify and note areas/problems that could recur in subsequent years or have a long-term effect for use in the subsequent years' audits.

PROGRAM ABUSE

8. During the course of the audit, be alert for potential Program abuse situations, but do not perform specific procedures. Read the Program abuse section. Intermediaries may choose to develop a Program Integrity Questionnaire for use during audit. If possible Program abuse exists, contact the audit supervisor immediately for further instruction. Do not discuss potential fraud or abuse situations with the provider. This might prejudice OIG's ability to successfully prosecute any subsequent referral of the issue. If a potential utilization problem requiring medical review comes to light, it should be referred to the medical review supervisor.

PREAUDIT (Continued)
HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

8

<u>STEP</u>	<u>PROCEDURE DESCRIPTION</u>	<u>AUDITOR'S INITIALS AND DATE</u>	<u>WP REF</u>
-------------	------------------------------	--	---------------

At the conclusion of the audit, attest that the auditor did not see any evidence of these items while performing the scoped audit procedures.

The following are examples of the appearance of potential fraud or abuse:

- A. Recording of personal expense items as provider cost for patient care;
- B. Arrangements by providers with employees, independent contractors, suppliers, and others that appear to be designed primarily to overcharge the health insurance program with various devices, for example, commissions, fee splitting, and arrangements used to siphon off or conceal illegal profits;
- C. A pattern of overutilization of services to inflate charges for purposes of increasing reimbursement;
- D. Any evidence of payroll entries and disbursements to personnel who provide little or no services to the provider;
- E. Provider's concealment of business activities that would affect eligibility for, or amount of, Program reimbursement, for example, undisclosed change of ownership or relationship with a supplying organization;
- F. Falsifying provider records in order to meet the conditions of participation;
- G. Charging to the Medicaid program costs not incurred or that are attributable to nonchargeable services or non-Program activities;
- H. Billing for supplies or equipment that are clearly unsuitable for the patient's needs, or are so lacking in quality or sufficiency for the purpose as to be virtually worthless;
- I. Duplicate billing that appears to be deliberate. This includes billing the Medicaid program twice or billing both Medicaid and the beneficiary for the same services;
- J. Deliberately receiving health insurance payments on the Medicaid account of other than the individual to whom the account belongs;
- K. Persistently and deliberately billing beneficiaries rather than Medicaid for covered services;

PREAUDIT (Continued)

9

HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

<u>STEP</u>	<u>PROCEDURE DESCRIPTION</u>	<u>AUDITOR'S INITIALS AND DATE</u>	<u>WP REF</u>
L.	Soliciting, offering, or receiving a kickback, bribe, or rebate;		
M.	An ineffectual board of directors and/or audit committee;		
N.	Abuse of internal accounting controls by administrative personnel;		
O.	Indications of personal financial problems of administrators or key staff;		
P.	Significant changes in business practices;		
Q.	Inadequate working capital or lack of flexibility in debt restrictions, such as working capital ratios and limitations on additional borrowing;		
R.	A complex corporate structure that does not appear to be warranted by the provider's size;		
S.	Frequent changes of legal counsel, independent auditors or key financial officers such as treasurer or controller;		
T.	Premature announcement of profit or loss or of future expectations;		
U.	Significant fluctuations on material account balances, financial interrelationships, inventory variances, or inventory turnover rates;		
V.	Unusually large payments in relation to services rendered by lawyers, consultants, agents, and others;		
W.	Difficulty in obtaining audit evidence with respect to unusual or unexplained entries, incomplete or missing documentation, or alterations in documentation or accounts;		
X.	Delays in responses or evasive responses by management to audit inquiries;		
Y.	Deliberately including cost, without disclosing the fact in the provider cost report, that specifically is nonreimbursable under the Medicaid regulations. This excludes instances where the provider discloses that the cost report is filed under protest and the protested issues and their reimbursement effect are disclosed;		
Z.	Repeat audit adjustments.		

PREAUDIT (Continued)

10

HOSPITAL AND SKILLED NURSING FACILITY AUDIT PROGRAM (1999)

<u>STEP</u>	<u>PROCEDURE DESCRIPTION</u>	<u>AUDITOR'S INITIALS AND DATE</u>	<u>WP REF</u>
-------------	------------------------------	--	---------------