

# **COLORADO INDIGENT CARE PROGRAM**

**FISCAL YEAR 2015-16**

**MANUAL**

## **SECTION III: PROVIDER AUDIT**

**EFFECTIVE: JULY 1, 2015**

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## **ARTICLE I.     AUDIT OVERVIEW**

### **Section 1.01   Provider Compliance Audit and Purpose**

To meet its fiduciary responsibility, the Colorado Indigent Care Program (CICP) requires that participating providers submit a provider compliance audit statement along with a Corrective Action Plan (CAP), when required, to the Department of Health Care Policy and Financing (Department). The purpose of the provider audit is to furnish the Department with a report that attests to provider compliance with specified provisions of the CICP provider agreement, regulations and manual. The following guidelines provide a basis for conducting the provider audit.

Those providers that receive \$1,000,000 or more annually in reimbursement from the CICP must submit an audit performed by an independent auditor. Those that receive under \$1,000,000 in reimbursement from the CICP may perform an internal audit rather than an external audit. An internal audit should be conducted by the facility's auditor. If the facility does not have an auditor on staff, then personnel who do not directly determine client CICP eligibility or handle CICP billing records should be chosen.

### **Section 1.02   Definitions**

- **Covered Services:** All medically necessary services that a provider customarily furnishes to patients and can lawfully offer to patients. These covered services include medical services furnished by participating physicians. The responsible physician must determine which covered services are medically necessary. The CICP does not reimburse providers for outpatient mental health benefits as a primary diagnosis, but does cover limited inpatient mental health services for a period of 30 days per calendar year per client.
- **Emergency Care:** Treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 25.5-3-103, C.R.S.
- **Client:** A person who meets the guidelines outlined in the Colorado Indigent Care Program Manual, which stipulates that the individual must have income and assets combined at or below 250% of the Federal Poverty Level (FPL).
- **Provider:** Any general hospital, birth center or community health clinic licensed or certified by the Department of Public Health and Environment enrolled with the CICP to provide medical services.
- **Non-Emergency Care:** Treatment for any conditions not included in the emergency care definition and any additional medical care for conditions the Department determines to be the most serious threat to the health of medically indigent persons.

### **Section 1.03 Provider Compliance Audit Statistics**

The Eligibility and Billing sections of the audit should use a sampling of CICIP client records to estimate the provider's overall compliance with the CICIP's rules and regulations. The following describes the philosophy behind the sample size selection and the risk level used in these sections of the audit. The criteria were selected based on the client population of large providers.

1. The level of precision, sometimes called sampling error, is the range that the true proportion of the population is estimated to be. The range is often expressed in percentage points (e.g.,  $\pm 5\%$ ). The Department has chosen a level of precision of  $\pm 20\%$ . A provider may choose to increase the level of precision to  $\pm 10\%$  by increasing the sample size from 25 to 100.
2. The confidence or risk level is based on the idea that when a population is repeatedly sampled, the average value of the attribute obtained by those samples is equal to the true population. In a normal distribution, approximately 95% of the sample values are within two standard deviations of the true population mean. The Department has chosen the risk of 10% that the sample does not represent the true population mean. The provider may not change this requirement and must explain all non-compliance results outside the 10% error rate.
3. The degree of variability in the attributes being measured refers to the distribution of attributes in the population. The Department has chosen the maximum variability of 50% in a population, which is a conservative sample size. The provider may not change this requirement.

### **Section 1.04 Records and Audit Documentation Retention and Availability**

All records, documents, reports, communications and other materials (except for medical records of CICIP clients) related to the participating CICIP Provider's and any subcontractor's participation in the CICIP shall be the property of the State and maintained in a central location by the provider as custodian thereof on behalf of the State, and shall be accessible to the State for a period of six (6) State fiscal years after the expiration of each State fiscal year. A further retention period may be necessary to resolve any matter which is pending at the expiration of each six (6) state fiscal year period.

The provider will keep the material associated with conducting this audit, such as the audit work papers and corrective action plans, for a period of six (6) State fiscal years following the conclusion of the audit. This must demonstrate that the audit was performed within the standards outlined in this section. If an audit by or on behalf of the federal and/or State government has begun, but is not completed at the end of the six (6) State fiscal year period, or if audit findings have not been resolved after the six (6) State fiscal year period, such materials shall be retained for six (6) months after the filing of the final audit report and response thereto. This material will not be submitted to the Department unless a direct request for the documentation is made.

## Section 1.05 Types of Audit

There are two types of audits associated with the CICP.

1. **Provider Compliance Audit:** The Provider Compliance Audit is the focus of this section. The compliance audit must be conducted annually in one of two ways: external or internal. The compliance audit is normally conducted as part of the regularly scheduled annual financial audit for each provider's institution. The auditor may perform a separate indigent care audit to test for compliance.
  - a. **External Audit:** If a provider received over \$1,000,000 in reimbursement from CICP in FY 2014-15, an independent auditor must perform an annual audit and submit a formal audit statement of compliance to the Department.
  - b. Hospital providers should refer to the Department's letter detailing their hospital provider fees and payments under the Colorado Health Care Affordability Act to determine if an external audit is required. Total CICP payments equal the sum of the CICP Supplemental Medicaid Payment and CICP Disproportionate Share Hospital (DSH) Payment.
  - c. Clinic providers should refer to the Department's letter(s) detailing their CICP clinic payments to determine if an external audit is required.
  - d. **Internal Audit:** If a provider received under \$1,000,000 in reimbursement from the CICP, the provider may elect to conduct the annual compliance audit internally, rather than externally. If the provider elects to perform an internal audit, the provider's administrator must submit an internal audit statement following the same provider compliance audit guidelines as the external audit. An internal audit should be conducted by the facility's auditor or compliance officer. If the facility does not have an auditor or compliance officer on staff, then the audit should be conducted by personnel who do not directly determine client CICP eligibility or handle CICP billing records.
2. **CICP Administrative Audit:** All providers are subject to an audit by the Department or a designee representing the Department. This audit will examine the provider's eligibility and billing records. The Department will notify the provider 60 days prior to conducting this audit. At that time, the provider will be notified regarding the audit's scope and criteria.

## Section 1.06 Provider Compliance Audit Submission

The provider will submit the compliance audit statement and CAP, if needed, to the Department within six (6) months of the completion of the annual financial audit related to the provider's annual CICP audit period. The audit period is for one (1) provider fiscal or calendar year or one state fiscal year.

The auditor should make a substantial effort to provide the completed compliance audit statement to the provider within 60 days from the date that the compliance audit was initiated.

It is the responsibility of the provider to submit the compliance audit statement to the CICP at:

**Department of Health Care Policy and Financing  
Colorado Indigent Care Program  
Attention: Eugene L. Advincula  
Cost Report Accountant  
1570 Grant Street  
Denver, CO 80203-1818**

OR

[Eugene.Advincula@state.co.us](mailto:Eugene.Advincula@state.co.us)

### **Section 1.07 Provider Compliance Audit Extensions**

Providers must seek an extension of the audit deadline by written request. The request must include a reason for the request and the date the compliance audit statement will be completed. The request for an extension must be received by the Department within 30 days of the provider's compliance audit statement due date.

Providers that fail to submit the compliance audit statement within the deadline specified in Section 1.06 while also failing to request an extension of the audit due date shall be considered out of compliance. Providers that are found out of compliance in the submission of the required compliance audit statement will be required to submit a CAP and may be subject to the penalty detailed in Section 1.12.

### **Section 1.08 Provider Compliance Audit Reporting Period**

The audit period is for one (1) provider's fiscal or calendar year or one (1) state fiscal year. The provider should maintain the same reporting period as previous CICIP Compliance Audits. **If the provider has a change in fiscal year or changes from calendar year to state fiscal year for the reporting period, an explanation of the change and the request of the new fiscal year must be sent to the Compliance Auditor for approval.**

### **Section 1.09 Provider Compliance Audit Sections**

The following audit guidelines represent the audit requirements and the reporting process. There are three separate components of the CICIP Compliance Audit.

1. **Eligibility Audit:** This audit examines only eligibility applications completed directly by the provider. Clients serviced by the provider under the CICIP but screened by another facility should not be included.
2. **Billing Audit:** This audit examines the provider's billing records and the summary information submitted to the CICIP.
3. **Programmatic Audit:** This entails a general review of the internal controls the provider utilizes to comply with the CICIP's regulations.

### **Section 1.10 Non Compliance**

Providers that are found to be out of compliance with any of the CICIP guidelines must implement a CAP. A statement from the provider's administration must be submitted to the CICIP with the compliance audit statement describing the plan of correction and an implementation date. Failure to submit a CAP will result in withholding CICIP payments until such a plan is received or the CICIP may redirect payments to compliant providers. *Providers are deemed out of compliance for any attribute in the Eligibility and Billing audit sections when the error rate for that specific attribute exceeds 10% of the sample or if the audit is received after the due date.*

### **Section 1.11 Provider Discontinuation in CICIP Participation**

A provider that discontinues CICIP participation must submit a letter 60 days prior to the termination date, and must have submitted an audit for all years that the provider participated in the CICIP. All audits must be found acceptable to the CICIP before any prorated payments are released to the provider.

### **Section 1.12 Penalty**

Failure to submit a compliance audit statement acceptable to the Department for any year in which a provider participates in the CICIP will result in the Department billing the provider for a full refund of monies received for the period in question or withholding payments until the audit has been submitted. Failure to pay this refund will result in this issue being turned over to the State for collection. Further, the Department will not contract with such a provider until the refund is paid in full.

### **Section 1.13 Auditor Responsibility**

The auditor is expected to understand the contents of the CICIP Manual and use the CICIP Manual as guidance for all audit procedures. Any disagreement between the audit procedure and the CICIP Manual should be documented in the audit compliance statement. Any disagreement between the audit procedures, CICIP Manual, and provider policies should be resolved between the auditor and provider. If the auditor and provider cannot reach resolution, jointly and concurrently, both parties should contact the Department for clarification. The auditor shall not contact the Department without prior consent from the provider.

## **ARTICLE II. PROVIDER COMPLIANCE AUDIT REQUIREMENTS**

### **Section 2.01 Eligibility Audit**

Use the formatted Table 1 from Article III, Provider Compliance Audit Format, to list error rates and explanations of non-compliance for items 1-8 listed in Section 2.03.

### **Section 2.02 Sample Size for Eligibility Audit**

1. A sample size of 25 CICIP client applications completed by the provider is mandatory.
  - a. If the provider completed fewer than 25 CICIP client applications in the audit period, then all applications completed by the provider must be included.
  - b. A provider may choose a sample size of 100 CICIP applications completed by the provider to reduce the sampling error (increase the level of precision) to plus or minus 10%.
2. The sample size shall be selected independently from the Billing Audit sample, unless the sample size is so small that all client records must be used for both audit sections or the Billing Audit sample is selected using the instructions under Section 2.05(2)(a). The Eligibility Audit sample is always determined prior to the Billing Audit sample.
3. The same sample will be used for each tested attribute in the Eligibility Audit. A separate sample is not necessary for each attribute.
4. Methods used to establish the sample size and design must be stated in the compliance audit statement.

### **Section 2.03 Required Items for the Eligibility Audit**

The following items shall be included in the Eligibility Audit:

1. Verification that an original client application is on file.
2. Verification that the guidelines under Section 1: Eligibility, of this CICIP Manual were followed and that the client application sheet was completed accurately, including income determinations. It is a requirement that every line on the client application be filled out to accurately complete the client application. The application must be signed and dated by all required parties.
3. Verification that the correct Ability-to-Pay scale was used and that the correct CICIP rate was calculated.
4. Verification that the applications were dated by all required parties.
5. Verification that the applications were signed by all required parties.

6. Verification that the client was not eligible for Medicaid or CHP+. The provider must have all potentially eligible clients apply for Medicaid or CHP+ unless the client would not be eligible due to categorical restrictions. The reason(s) for not directing a potentially eligible client to apply for Medicaid or CHP+ must be documented or noted by checking the appropriate check box on the CICP client application. Clients who are potentially eligible for Medicaid or CHP+ will need to have a denial letter from the appropriate program to accurately complete the CICP client application. If the provider has deemed the applicant not potentially eligible due to not being categorically eligible the provider must check the “other” box and include a brief comment.
7. Verification that the income and extraordinary expense documentation for the application is maintained on file.
  - a. There must be documentation that the provider made a reasonable effort in requesting and obtaining documentation of financial resources for the client. Different situations may require different documentation. In some circumstances, no documentation may be available (e.g., if the client is a migrant worker, homeless or transient). In such instances, the provider must state in the remarks section, or on an attached page, why income was calculated without supporting documentation.
  - b. Copy of one full month’s paycheck stubs will suffice as income documentation.
  - c. Documentation must be maintained in the provider’s records for cases where a client rating was not completed, when an applicant is denied CICP because of the patient's lack of cooperation or inability to supply the needed financial data.
8. In cases for which the provider has changed a client’s rating to a lower rate through the use of Management Exception (see Section 1: Eligibility, of this CICP Manual), written documentation must exist to justify the change. The auditor must also state how many Management Exceptions were found in the sample, as well as the percentage of total ratings such exceptions represent.
9. Verification that the client’s “Affidavit for Lawful Presence” is on file. Effective January 1, 2008, the Affidavit that must be on file must be identical to the Affidavit under Section VI: Client Affidavit and Application of this CICP Manual.
  - a. Verification that the Affidavit was signed by the client and dated. The client must have either checked the line indicating that they are a United States citizen or checked the line indicating that they are a Legal Permanent Resident or otherwise lawfully present in the United States.
  - b. Effective January 1, 2008, verification that the provider filled out the shaded box on the Affidavit called “For Eligibility Technician Use,” noting the type of document that verified lawful presence. However, if the applicant is not able to provide any of the documents listed and is a United States Citizen (or a person from American Samoa, Swains Island or Northern Mariana Islands) the applicant may complete the self declaration statement. In this case, the shaded box would not be filled out by the

Eligibility Technician. Verification of lawful presence must be confirmed in SAVE for all non-U.S. citizens. The date the provider completed the lawful presence verification must be indicated in the shaded box on the affidavit.

- c. Verification that photocopies of legal presence documents submitted by the client are retained in the client's application file. For clients who are not U.S. citizens, the printout of the Verification Result Screen from the SAVE search must also be retained in the client's application file. Note, U.S. citizens are allowed to sign the self-declaration statement at the bottom of the Affidavit only after the provider attempts to secure other acceptable documentation. The provider should document what documents were requested.

#### **Section 2.04 Billing Audit**

Use the formatted Table 2 from Article III, Provider Compliance Audit Format, to list error rates and explanations of non-compliance for items 1-6 listed in Section 2.06.

#### **Section 2.05 Sample Size for Billing Audit**

1. A review sample size of 25 CICP unique client billing records for which the facility provided services to the client under the CICP is mandatory.
  - a. If the facility provided services under the CICP to fewer than 25 CICP clients in the audit period, then all CICP client billing records must be included in the review.
  - b. A provider may choose a sample size of 100 CICP client billing records to reduce the sampling error (increase the level of precision) to plus or minus 10%.
2. In collaboration with the auditor, the provider shall decide which of the following methods to utilize in determining the sample size for the Billing Audit:
  - a. The sample size shall be selected independently from the Eligibility Audit sample, unless the sample size is so small that all client records must be used for both audit sections.
  - b. The sample size shall be selected directly from the Eligibility Audit sample, such that a random billing record will be selected for each client application selected under the random sample in the Eligibility Audit. The Eligibility Audit sample is always determined prior to the Billing Audit sample.
3. The sample selected must include billing records for patients who have third-party insurance coverage for part of their medical services in the proportion they represent CICP clients.
4. The sample will be used for each tested attribute in the Billing Audit. A separate sample is not necessary for each attribute.
5. Methods used to establish the sample size and design must be stated in the compliance audit statement.

## **Section 2.06 Required Items for the Billing Audit**

The following items shall be included in the Billing Audit:

1. Verification that billing records are available within the facility's billing system or other archive.
2. Verification that the client was eligible for the CICIP. Documentation could include a copy of the CICIP application or copy of the client's CICIP card.
3. If applicable, verification that reimbursement was sought from a third party associated with the billing record.
4. Verification that the patient was charged the correct copayment.
5. Verification that the billing record was translated correctly from the provider's billing system to the billing information reported to the Department:
  - a. Verification that the billed charge was included in the total charge reported to the Department.
  - b. Verification that any reimbursement due from a third party associated with the charge was included in the third party liability figure reported to the Department.
  - c. Verification that any client copayment associated with the charge was included in the client liability figure reported to the Department.
6. Verification that the total charge for the service was the same charge billed to non-CICIP patients during the same period.

## **Section 2.07 Programmatic Audit**

The following items do not have an error rate associated with the test. The provider is either compliant or noncompliant with the attribute. Using the formatted Table 3 from Article III, Provider Compliance Audit Format, state if the provider was compliant or noncompliant, and provide an explanation, for items 1-10 listed below.

## **Section 2.08 Required Items for the Programmatic Audit**

The following items shall be included in the Programmatic Audit:

1. Verification that the provider has maintained the client eligibility applications and associated documents, and the Affidavit for Lawful Presence and associated documents for a period of six (6) state fiscal years as required by the agreement between the CICIP and the provider. No sampling is necessary to satisfy this requirement. This is a general review of the internal controls and procedures for maintaining these records. See Section 1.04, Records and Audit Documentation Retention and Availability.

2. Verification that the provider has maintained the client billing records and associated documents for a period of six (6) state fiscal years as required by the agreement between the CICIP and the facility. No sampling is necessary to satisfy this requirement. This is a general review of the internal controls and procedures for maintaining these records. See Section 1.04, Records and Audit Documentation Retention and Availability.
3. Verification that the provider's detail client billing records support the summary billing information submitted to the CICIP, as explained in the CICIP Manual. If the provider has physician participation in the CICIP, detail client billing records must exist to support the information submitted to the Department. The auditor shall verify that detail client billing records exist to support all summary information submitted to the Department. This is not meant to be an all-encompassing review of every billing record and the auditor determines the tests on which to render a statement or opinion. This requirement is intended to include verification or testing of billing records for the current audit period only, not for the period of six (6) state fiscal years as required above.
4. Verification that the provider complied with legislated medical service priorities. This means that, at minimum, emergency medical care was provided to all medically indigent patients for the full contract year. The second priority is to provide any additional medical care that is a serious threat to the health of the medically indigent. The third priority is providing any other additional medical care. This requirement is intended to include verification or testing for the current audit period only, not for the six (6) state fiscal years required above.
5. Review of utilization review activities in general to ensure that indigent patients were included in the sample receiving utilization review. (The auditor is not responsible for conducting a utilization review or for reviewing any individual patient's medical records.) This requirement is intended to include verification or testing for the current audit period only, not for the six (6) state fiscal years as required above.
6. Review of the patient appeals process to ensure that appeal guidelines and patient notifications, as defined in the CICIP Manual, are fulfilled. This requirement is intended to include verification or testing for the current audit period only, not for the six (6) state fiscal years as required above.
7. Review of the provider's internal controls. The audit compliance statement needs to indicate that a review of internal controls was conducted. Any weaknesses in internal controls must be reported in the audit compliance statement. This requirement is intended to include verification or testing for the current audit period only, not for the six (6) state fiscal years as required above.
8. Hospital Providers Only: If the provider has physician participation in the CICIP, verification that fully executed contracts exists between the provider facility and the physician/physician group. This requirement is for hospitals only and is intended to include verification or testing for the current audit period only, not for the six (6) state fiscal years as required above.

9. The auditor should document any disagreement between the audit procedure and the CICIP Manual. This attribute is available for the auditor to request clarification in future additions of the CICIP Manual.

### **Section 2.09 General Information Requirement**

Compliance statements must contain the following:

1. Name of auditor(s) or auditing firm
2. Address of auditor(s) or auditing firm
3. Starting and ending dates of the audited period
4. Starting and ending dates for the audit
5. The name and address of the audited provider
6. The name of the contact person at audited provider

It is the responsibility of the provider to submit the audit compliance statement to the Department at:

**Department of Health Care Policy and Financing  
Colorado Indigent Care Program-Compliance Audit  
Attn: Eugene L. Advincula  
Cost Report Accountant  
1570 Grant Street  
Denver, CO 80203-1818**

OR

[Eugene.Advincula@state.co.us](mailto:Eugene.Advincula@state.co.us)

**ARTICLE III. PROVIDER COMPLIANCE AUDIT FORMAT**

The following format shall be used for reporting the audit results. This general template can be modified by the auditor, but the required information cannot change.

**General Information Requirement**

1. Name of auditor(s) or auditing firm: \_\_\_\_\_
2. Address of auditor(s) or auditing firm: \_\_\_\_\_
3. Starting and ending dates of the audited period: \_\_\_\_\_
4. Starting and ending dates for the audit: \_\_\_\_\_
5. The name and address of the audited provider: \_\_\_\_\_
6. The name of the contact person at audited provider: \_\_\_\_\_

**Eligibility Audit**

Explanation of how the Eligibility Audit sample size was established:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Table 1: Required Areas of Eligibility Audit**

<b>Attribute</b>	<b>Sample Size</b>	<b>Errors Noted</b>	<b>Error Percent</b>	<b>Compliance<sup>1</sup> (Yes/No)</b>
<b>E1</b> Application on File				
<b>E2</b> Manual Used Correctly				
<b>E3</b> Correct CICP Rating				
<b>E4</b> Application Dated				
<b>E5</b> Application Signed				
<b>E6</b> Not eligible for Medicaid or CHP+				

<sup>1</sup> The attribute is out of compliance if the error rate exceeds 10% for the specific attribute tested.

Attribute	Sample Size	Errors Noted	Error Percent	Compliance <sup>1</sup> (Yes/No)
<b>E7</b> Documentation				
<b>E8</b> Management Exception				
<b>E9a</b> Affidavit was signed by the client and dated.				
<b>E9b</b> Provider filled out the shaded box marked "For Eligibility Technician Use"				
<b>E9c</b> Photocopies of legal presence documents submitted by client are in the client's application file.				

**Explanation of Compliance/Non-Compliance for Eligibility Audit**

Attribute E1: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Attribute E2: \_\_\_\_\_  
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 \_\_\_\_\_  
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 \_\_\_\_\_

Attribute E3: \_\_\_\_\_  
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Attribute E4: \_\_\_\_\_  
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Attribute E5: \_\_\_\_\_  
\_\_\_\_\_  
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Attribute E6: \_\_\_\_\_  
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Attribute E7: \_\_\_\_\_  
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Attribute E8: \_\_\_\_\_  
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\_\_\_\_\_  
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Attribute E9a: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attribute E9b: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attribute E9c: \_\_\_\_\_  
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\_\_\_\_\_  
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**Billing Audit**

Explanation of how the Billing Audit sample size was established:

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**Table 2: Required Areas of Billing Audit**

<b>Attribute</b>	<b>Sample Size</b>	<b>Errors Noted</b>	<b>Error Percent</b>	<b>Compliance<sup>2</sup> (Yes/No)</b>
<b>B1</b> Billing Record Available				
<b>B2</b> Client Eligible				
<b>B3</b> Third Party				
<b>B4</b> Correct Copay				
<b>B5a</b> Translated – Total Charge				
<b>B5b</b> Translated – Third Party				
<b>B5c</b> Translated – Copay				
<b>B6</b> Same Charge				

**Explanation of Compliance/Non-Compliance for Billing Audit**

Attribute B1: \_\_\_\_\_

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Attribute B2: \_\_\_\_\_

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<sup>2</sup> The attribute is out of compliance if the error rate exceeds 10% for the specific attribute tested.

Attribute B3: \_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

Attribute B4: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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Attribute B5a: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attribute B5b: \_\_\_\_\_  
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\_\_\_\_\_  
\_\_\_\_\_

Attribute B5c: \_\_\_\_\_  
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Attribute B6: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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**Programmatic Audit**

**Table 3: Required Areas of Programmatic Audit**

<b>Attribute</b>	<b>Compliance<sup>3</sup> (Yes/No)</b>
<b>P1</b> Client Applications	
<b>P2</b> Billing Records	
<b>P3</b> Reporting	
<b>P4</b> Legislative Priorities	
<b>P5</b> Utilization Review	
<b>P6</b> Client Appeals	
<b>P7</b> Internal Controls	
<b>P8</b> Physician Contracts	

**Explanation of Compliance/Non-Compliance for Programmatic Audit**

Attribute P1: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Attribute P2: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Attribute P3: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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<sup>3</sup> The attribute is out of compliance if the auditor finds significant evidence that the specific attribute was not fulfilled.

Attribute P4: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attribute P5: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attribute P6: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attribute P7: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Attribute P8: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## **ARTICLE IV. NON-COMPLIANCE**

### **Section 4.01 Eligibility and Billing Audit Sections**

Providers are deemed out of compliance for the Eligibility and Billing audit sections when any of the attributes have an error rate that exceeds 10%.

### **Section 4.02 Programmatic Audit Section**

Providers are deemed out of compliance with the Programmatic audit section if the auditor finds significant evidence that any of the attributes were not fulfilled.

### **Section 4.03 Audit Submittal Date**

Providers are deemed out of compliance when the audit is submitted past the due date, which is six (6) months past the end of the provider's annual CICP audit period.

### **Section 4.04 Corrective Action Plan Requirement**

Providers that are out of compliance with any of the CICP's audit attributes or if the audit was submitted late, must submit and implement a CAP.

1. A CAP must be submitted to the Department by the provider's administration with the provider's compliance audit statement.
2. The CAP must describe how each attribute found out of compliance will be corrected and include an implementation date. If the audit is submitted late the provider must describe how the tardiness will be corrected for the next fiscal year submission.
3. Providers shall not state that the level of sampling error of 20% was too high as a reason for non-compliance. If a provider feels that the sampling error of 20% misrepresents their actual population, then the provider should use a sampling error of only 10%. This requires increasing the sample size to 100 from 25 on all attributes in the Eligibility and Billing sections of the audit.
4. Failure to submit a suitable CAP will result in the Department withholding CICP payments until such a plan is received.
5. Send the Provider Compliance Audit Statement and CAP to:

**Department of Health Care Policy and Financing  
Colorado Indigent Care Program-Compliance Audit  
Attn: Eugene L. Advincula, Cost Report Accountant  
1570 Grant St.  
Denver, CO 80203-1818**

OR

[Eugene.Advincula@state.co.us](mailto:Eugene.Advincula@state.co.us)