Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

NOVITAS SOLUTIONS, INC., REOPENED AND CORRECTED COST REPORT FINAL SETTLEMENTS WITH OBVIOUS ERRORS TO COLLECT OVERPAYMENTS MADE TO MEDICARE PROVIDERS

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

Amy J. Frontz
Deputy Inspector General
for Audit Services

September 2024
A-06-23-05001

Office of Inspector General

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HHS Office of Inspector General

REPORT HIGHLIGHTS

September 2024 | A-06-23-05001

Novitas Solutions, Inc., Reopened and Corrected Cost Report Final Settlements With Obvious Errors To Collect Overpayments Made to Medicare Providers

Why OIG Did This Audit

- Medicare providers are required to submit to their Medicare administrative contractor (MAC) annual cost reports, which are financial documents that convey the provider's costs associated with providing services to Medicare enrollees. MACs use them to determine the final amount of Medicare program reimbursement due providers for their cost reporting period (the final settlement of the cost report).
- MACs may audit a provider's cost report after performing a mandatory desk review to further verify compliance with the law, regulations, and Medicare manual instructions relating to the final settlement of the cost report.
- CMS's primary goal is for the MACs to arrive at correct final settlements of the cost report. If there is an error made in the final settlement, the cost report final settlement may be reopened and adjusted to correct for the error. We performed this audit of one MAC, Novitas Solutions, Inc. (Novitas), to determine whether Novitas reopened and corrected cost report final settlements because of obvious errors in their audits.

What OIG Found

Novitas reopened 8 of 281 (2.8 percent) audited cost reports to correct the final settlements that contained obvious errors. These 8 audited cost reports required 10 reopenings because of human errors by Novitas.

- As a result of these 10 errors, the reopened cost reports resulted in corrected final settlements to providers totaling $1.1 million in net overpayments, consisting of $1.4 million in overpayments and $285,076 in underpayments.
- Auditors and supervisors required additional education on the criteria and audit requirements applicable to certain payments and bad debts. Novitas' procedures for review by supervisors did not detect the incorrect audit adjustments.
- The risk exists that delays in the finalization of audited cost reports could prevent some Medicare funds from being expended in the most efficient and effective ways.

What OIG Recommends

We recommend that Novitas:

1. develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements and
2. develop and implement enhanced procedures so that supervisors are better qualified to detect incorrect audit adjustments.

Novitas agreed with both of our recommendations and described actions it has taken to address them.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare-certified institutional providers, including hospitals, skilled nursing facilities, and home health agencies, among others, are required to submit an annual cost report to their Medicare administrative contractor (MAC).[1] Cost reports are financial documents that convey the provider's costs associated with providing services to people enrolled in Medicare and are used by MACs to determine the final amount of Medicare program reimbursement due providers for their cost reporting period (i.e., accounting year).

A MAC, as part of its Medicare Integrity Program activities, can audit a provider's cost report after performing a mandatory desk review to further verify compliance with the law, regulations, and Medicare manual instructions relating to the determination of reimbursement amounts.[2] These amounts include graduate medical education (GME) payments, indirect medical education (IME) payments, disproportionate share hospital (DSH) payments, payments associated with bad debts, and certain other amounts, as well as cost-reimbursed items, such as reasonable costs claimed by cancer hospitals or critical access hospitals.[3] At the conclusion of the MAC's audit, the MAC issues a Notice of Program Reimbursement (NPR) to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to Medicare.

The Centers for Medicare & Medicaid Services' (CMS's) primary goal is for MACs to arrive at correct settlements of the cost report.[4] If there is an error made in the final settlement, the cost report final settlement can be reopened and adjusted to correct for the error.[5]

Some cost reports that have been audited and settled are later reopened to correct the final settlement. The MACs maintain supporting documents for the cost reports that they reopen that include the reasons for the reopenings. These supporting documents include information related to the monetary adjustments to correct the final settlements. MACs submit cost report-related information to CMS.

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[1] Social Security Act (the Act) § 1815(a); 42 CFR § 405.1801(b)(1); 42 CFR § 413.24(f).

[2] The Medicare Integrity Program was established under the provisions of the Act § 1893, which describes program integrity activities to prevent or detect improper payments.

[3] GME payments are meant to reimburse providers for the direct cost of training medical students. IME payments are meant to reimburse providers for the indirect cost of training medical students. DSH payments are meant to reimburse hospitals for the cost of provided care for low-income patients. These and other payments constitute the "reimbursable amounts" that are the focus of this report.

[4] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 60.5.

[5] We refer to the reopening of cost report final settlements as the "reopening of cost reports" throughout the remainder of the report.

We performed this audit to determine whether Novitas Solutions, Inc. (Novitas), which currently has multiple MAC jurisdictions covering 11 States and the District of Columbia, reopened and corrected cost report final settlements because of audit errors.[6]

OBJECTIVE

Our objective was to determine whether, for the audited cost reports that Novitas reopened to correct the final settlements, any of the audits contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions and were caused by Novitas**.**

BACKGROUND

Medicare Program

Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. Medicare Part A provides inpatient hospital insurance benefits and coverage for extended care services for patients after discharge, and Medicare Part B provides supplementary medical insurance for medical and other health services, including coverage of therapy services. CMS administers the Medicare program and contracts with MACs to, among other things, process and pay claims submitted by health care providers.

Medicare Cost Reports

Certain institutional providers, such as hospitals, skilled nursing facilities, home health agencies, renal dialysis centers, hospices, rural health clinics, community mental health centers, federally qualified health centers, and organ procurement organizations, are required to submit annual cost reports to their MAC. CMS uses the financial and statistical data reported in the cost reports to set Medicare payment rates and calculate reimbursements for provider spending on medical education, uncompensated care, low-income patients, and high-cost Medicare cases. The cost report contains a series of worksheets with information on facility characteristics, health care utilization, employee salary and wage data, facility costs and charges, and Medicare settlement data.

Providers attest to the accuracy of the data when submitting their cost reports. After acceptance of each cost report, the MAC performs a tentative settlement, then performs a desk review of the cost report and conducts an audit, as appropriate, before final settlement.[7]

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[6] On November 1, 2023, we issued a report to Noridian Healthcare Solutions titled *Noridian Healthcare Solutions Reopened and Corrected Cost Report Final Settlements to Collect $11 Million in Net Overpayments That Had Been Made to Medicare Providers* (A-06-22-05000).

[7] 42 CFR § 413.64(f)(2); *Provider Reimbursement Manual*, CMS Pub. No. 15-1, part 1, § 2408.2; *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 20.

Medicare Administrative Contractor Cost Report Reviews

MACs serve as the primary operational contact between the Medicare fee-for-service program and the health care providers enrolled in the program. MACs perform many administrative activities, including desk reviews and audits of cost reports.

MACs must conduct desk reviews of cost reports for all providers that file a Medicare cost report, with the exception of cost reports for hospices and for providers that have low or no Medicare utilization. A desk review is an analysis of the provider's cost report to evaluate its adequacy and completeness and determine the accuracy and reasonableness of the data contained in the cost report. This process does not include detailed verification and is designed to identify issues that may warrant additional review. The purpose of the desk review is to determine whether the cost report can be settled without an audit or whether an audit is necessary.[8] In contrast, an audit is an examination of financial transactions that tests the provider's compliance with the law, regulations, and Medicare manual instructions.

In selecting cost reports to audit, the MAC uses its professional judgment in determining which providers represent the greatest risk of incorrect payment.[9] MACs perform audits in compliance with the Government Auditing Standards issued by the Comptroller General of the United States and use desk reviews and empirical knowledge of providers to define audit objectives and the scope and methodology to achieve those objectives.[10] If the MAC finds that claimed amounts in the cost report are not in accordance with the law, regulations, or Medicare manual instructions, it can create an audit adjustment to ensure that the cost report complies with those requirements.[11] All audit work performed is subject to supervisory review to ensure audit quality.[12] At the conclusion of the audit, the MAC then issues an NPR to the provider. As the final settlement document, the NPR shows whether payment is owed to the provider or to the Medicare program [13]

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[8] *Medicare Financial Management Manual,* CMS Pub. No. 100-06, chapter 8, § 20.1.

[9] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 40.

[10] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, §§ 30.1, 50.1, and 80.

[11] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, §§ 60.11 and 70.4.

[12] *Medicare Financial Management Manual*, CMS Pub. No. 100-06, chapter 8, § 60.13.

[13] For example, a hypothetical provider claims a total reimbursement of $100,000,000 on its cost report, and the provider has been paid throughout the year for claims and with other payments totaling $95,000,000. The MAC's auditor creates an audit adjustment to the worksheets of $2,000,000 to ensure that the cost report complies with Medicare regulations and Medicare manual instructions. Accordingly, the NPR would specify that a $3,000,000 payment is due the provider at the final settlement.

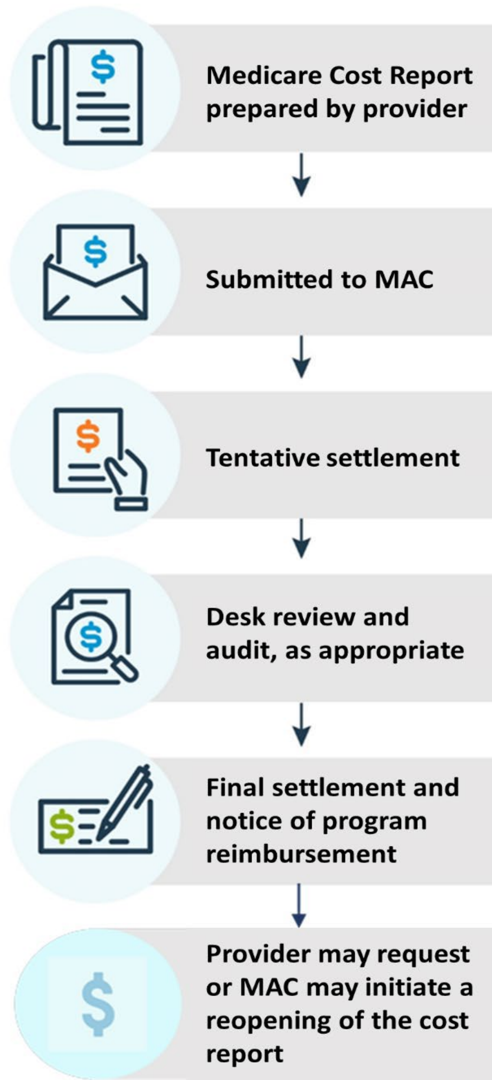
Cost Report Reopenings

A cost report final settlement may be reopened at the request of the provider or on the MAC's own initiative within 3 years of the date of the NPR to re-examine and adjust the final determination of the amount of total reimbursement due the provider (42 CFR § 405.1885).[14] The decision by the MAC to reopen a settled cost report generally depends on whether new and material evidence has been submitted by the provider, an error was made during the final settlement process, or the settled cost report is found to be inconsistent with the law, regulations, and manual instructions (*Provider Reimbursement Manual*, part I, § 2931.2).

The figure on the next page depicts the Medicare cost report submission, review, settlement (tentative and final), and reopening process.

[14] A MAC may reopen and revise a final settlement at any time if it is established that the determination or decision was procured by fraud or similar fault of any party to the determination or decision.

Figure: Medicare Cost Report Process



HOW WE CONDUCTED THIS AUDIT

We obtained information regarding 281 audited cost reports ending in fiscal years 2016 and 2017 [15] for both Novitas' MAC jurisdictions and determined whether they had been reopened. We did not review audited cost reports that were reopened based on directions by CMS.[16] We

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[15] We audited reopened cost reports for fiscal years ending (FYE) in 2016 and 2017 because there can be a significant delay, more than 3 years, between the cost report FYE and the reopened and revised final settlement to correct any errors associated with the MAC's audit. The figure on this page depicts the Medicare cost report submission, review, settlement (tentative and final), and reopening process.

[16] These exclusions do not include those audited cost reports that were reopened at the direction of the CMS Quality Assurance Surveillance Plan (QASP). The QASP conducts reviews of cost reports to ensure MAC compliance with requirements.

also did not review audited cost reports involving new information or for Medicare payments for new Medicaid patient days or new patient days for both Medicare and Supplemental Security Income (SSI).[17] Of the 281 audited cost reports, Novitas reopened 115 of them 1 or more times, for a total of 167 reopenings.[18] Novitas officials notified us that 8 audited cost reports were reopened 1 or more times, for a total of 10 reopenings, to correct the final settlement for obvious errors.[19] For those 10 cost report reopenings, we obtained workpapers, audit adjustments, and final settlement summaries to identify whether the provider requested a reopening or Novitas initiated the reopening, the reasons for the reopening, and the effect of the corrected final settlement.

When applicable, Novitas officials furnished, and we reviewed, a description of the reasons the audited cost reports were reopened to correct final settlements that contained obvious errors or were inconsistent with the law, regulations, or Medicare manual instructions.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

FINDING

EIGHT REOPENED COST REPORTS INVOLVED OBVIOUS ERRORS BY NOVITAS

Novitas reopened 8 of 281 (2.8 percent) audited cost reports, some more than once, for a total of 10 reopenings, to correct the final settlements that contained obvious errors caused by Novitas personnel. Some of these errors involved omitting, misclassifying, misreporting, or miscalculating audit adjustments. The next page describes two examples of reopening adjustments for obvious errors in cost report final settlements.

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[17] We considered the reasons for these reopened cost reports to constitute new and material evidence that was not within our scope. The term "new Medicaid patient days" refers to patient days for individuals who were eligible for Medicaid. The other category of new patient days described here consists of patient days for individuals who were eligible for both Medicare and SSI. We treated these patient days as new because they were claimed for the first time in the reopened cost reports; therefore, they had no bearing on Novitas' quality and performance on its audit of the initial cost reports.

[18] We did not review 157 cost report reopenings because they had been reopened and settled based on directions from CMS or because of new and material evidence.

[19] Novitas defines an "obvious error" as an error that occurred to the initial determination or decision based on (1) incorrect evidence on file on which the determination was based or (2) any evidence of record anywhere in the contractor's Medicare file or in CMS files at the time such initial determination or decision was made.

According to Novitas, for one cost report, CMS Quality Assurance requested a reopening of the final settled cost report because Novitas did not reduce payments for hospitalizations associated with hospital-acquired conditions (HACs). When patients contract HACs, which could be postoperative infections or pressure ulcers, while at the hospital, CMS may reduce payments by 1 percent. Novitas did not apply an HAC reduction and reopened this cost report to show that the provider is subject to the HAC reduction. Reopening adjustments of the final settlement corrected the overpayment of $271,939 to this provider.

According to Novitas, for another cost report, the MAC reopened the final settled cost report on its own initiative because its audit did not account for an overpayment check from the provider. Reopening adjustments of the final settlement corrected the underpayment of $175,323 to this provider.

Novitas officials reported that auditors and supervisors required additional training applicable to certain payments and bad debts. Additionally, Novitas' procedures for review by supervisors did not detect the incorrect audit adjustments.

As a result of the 10 errors in the 8 cost reports, the reopened cost reports resulted in corrected final settlements to providers totaling $1,072,560 in net overpayments (which consisted of $1,357,636 in overpayments and $285,076 in underpayments). Moreover, although an analysis of time delays was not part of our methodology for this audit, the risk exists that delays in the finalization of audited cost reports could prevent some Medicare funds from being expended in the most efficient and effective ways.

Appendix B provides the details of the audit adjustment errors, including Novitas' descriptions of why the errors occurred, information on specific Medicare requirements, and identification of who detected the error.

RECOMMENDATIONS

We recommend that Novitas Solutions, Inc.:

- develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements and

- develop and implement enhanced procedures so that supervisors are better qualified to detect incorrect audit adjustments.

NOVITAS SOLUTIONS, INC., COMMENTS

In written comments on our draft report, Novitas agreed with all of our recommendations and described corrective actions that it had taken to address them. Specifically, for the first recommendation, Novitas indicated that it will continue to develop and deliver continuing education to auditors based on needs and requirements identified by their training team, audit staff, and CMS. Novitas recently expanded the number of audits selected for quality review and each month shares high-level findings with team members to ensure they are aware of the issues. For the second recommendation, Novitas implemented a process to perform verification of the adjustments against the electronic files, used to generate the final cost report, prior to issuing final settlement.

Novitas' comments appear in their entirety as Appendix C.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We obtained information regarding 281 audited cost reports ending in fiscal years 2016 and 2017 for Novitas' two MAC jurisdictions (JH and JL) and determined whether they had been reopened. Of these 281 audited cost reports, Novitas had reopened 115 of them, 1 or more times, for a total of 167 cost report reopenings. Of the 167 reopenings of the cost reports, we did not review 157 cost report reopenings because they had been reopened and settled based on directions from CMS or because of new and material evidence. The removal of these cost report reopenings left 10 cost report reopenings for further review.

We assessed internal controls necessary to satisfy the audit objective. In particular, we gained an understanding of and reviewed Novitas' policies and procedures regarding supervisory review before the final settlement of cost reports. Based on this review, we assessed Novitas' ability to detect errors in the audited cost reports.

We performed audit work from August 2023 through August 2024.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and Medicare manual instructions;
- obtained and reviewed information from Novitas related to audited cost reports and subsequent reopenings for fiscal years 2016 and 2017;
- removed 157 cost report reopenings from our scope of 167 reopenings because the cost reports:
    - involved reopenings based on CMS direction (97 cost report reopenings) and were not related to the quality and performance of Novitas' audits,
    - involved reopenings for new and material evidence because the providers claimed new patient days related to Medicaid and SSI (45 cost report reopenings) (footnote 17),
    - had been reopened based on new and material evidence claimed for the first time in the reopening (13 cost report reopenings) and thus had no bearing on the quality and performance of Novitas' audits of the initial cost reports, and

- involved reopenings for Health Information Technology for Economic and Clinical Health Act payments based on a CMS corrective action plan (2 cost report reopenings). These reopenings did not involve any payment impact.

- for the remaining 10 audited cost report reopenings, obtained and reviewed the reopening documentation, including reasons for the reopening, root causes of the errors, and effect of the reopened final settlements;

- obtained and reviewed Novitas' policies and procedures for conducting audits, the reopening process, and supervisory review.

- determined the adequacy of supervisory review by Novitas to detect errors in the audited cost reports; and

- discussed the results of our audit with Novitas officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: AUDIT ERROR DETAILS

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Novitas on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
1	Novitas misreported a HAC reduction.	Team member did not detect incorrect settlement amount/ Supervisor did not detect incorrect audit adjustment.	As an incentive for hospitals to reduce HACs, the amount of payment for discharges will be equal to 99% of the amount of payment that would otherwise apply to such discharges (Social Security Act § 1886(p); 42 CFR § 412.172).	CMS Quality Assurance	$271,939
2	Novitas misreported the finalized cost report settlement.	Auditor/ Reviewer did not detect missed adjustment.	Cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to beneficiaries (CMS Pub. 15-1, § 2304). Providers receiving payment on the basis of reimbursable cost must provide adequate cost data (42 CFR § 413.24).	CMS Quality Assurance	60
3	Novitas misreported the inpatient rehabilitation facility low-income patient adjustment (LIP).	Auditor/ Reviewer did not detect missed adjustment.	CMS adjusts the Federal prospective payment, on a facility basis, for the proportion of LIP that receive inpatient rehabilitation services as determined by CMS (42 CFR § 412.624(e)(2)).	Novitas	20,234
4	Novitas omitted overpayment	Auditor/ Reviewer did not detect	Under the prospective payment systems, Medicare's total payment	Provider	(175,323)

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Novitas on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
	check from the provider.	missed adjustment.	for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the appropriate prospective payment rates for operating costs, capital-related costs, and additional costs and payments as applicable (42 CFR § 412.110). The provider must furnish such information to the contractor as may be necessary to— (i) Assure proper payment by the program, (ii) Receive program payments; and (iii) Satisfy program overpayment determinations (42 CFR § 413.20).		
5	Novitas miscalculated certain outpatient dual-eligible bad debts.	Auditor and Reviewer need additional training.	Allowable bad debts attributable to the deductibles and coinsurance amounts are reimbursable under the Program (42 CFR § 413.89; CMS Pub. 15-1, § 300); cost information as developed by the provider must be current, accurate, and in sufficient detail to support payments made for services rendered to	Novitas	11,094

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Novitas on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			beneficiaries (CMS Pub. 15-1, § 2304).		
6	Novitas miscalculated per-resident amount (PRA).	Reimbursement reporting error.	The contractor determines a PRA for each hospital's cost reporting period (42 CFR § 413.77). Direct GME payments attributable to additional full-time equivalent residents are calculated using the locality-adjusted national average PRA (42 CFR § 413.77(g)). Use worksheet E-4 to calculate direct GME costs related to certain approved hospital teaching programs (CMS Pub. 15-2, § 4034).	Novitas	120,796
7	Novitas misclassified costs associated with paramedical education as allowable.	Auditor/ Reviewer did not detect incorrect adjustment.	Medicare will make payments to hospitals for the cost of nursing and allied health education activities based on a reasonable cost basis for approved educational activities including costs of non-provider-based programs that meet certain criteria (42 CFR § 413.85).	Provider	(109,753)
8	Novitas misclassified pastoral care tuition.	Auditor/ Reviewer did not detect incorrect adjustment.	Medicare will make payments to hospitals for the cost of nursing and allied health education activities based on a	Novitas	10,962

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Novitas on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			reasonable cost basis for approved educational activities including costs of non-provider-based programs that meet certain criteria (42 CFR § 413.85).		
9	Novitas omitted tentative payments.	Auditor and Reviewer need additional training.	Under the prospective payment systems, Medicare's total payment for inpatient hospital services furnished to a Medicare beneficiary by a hospital will equal the sum of the appropriate prospective payment rates for operating costs, capital-related costs, and additional costs and payments as applicable (42 CFR § 412.110). The provider must furnish such information to the contractor as may be necessary to— (i) Assure proper payment by the program, (ii) Receive program payments; and (iii) Satisfy program overpayment determinations (42 CFR § 413.20).	Provider	596,201
10	Novitas omitted tentative payments.	Auditor and Reviewer need additional training.	Hospitals are generally paid for hospital inpatient operating costs and capital-related costs for each discharge based on	Novitas	326,350

Reopened Audited Cost Reports With Errors	Description of the Error*	Why Error Occurred*	Medicare Requirements as Cited by Novitas on the Audit Adjustment Report*	Error Detected by*, †	Over-payment (Under-payment) *, ‡
			the submission of a discharge bill (42 CFR § 412.116). After CMS reviews a cost report and any audit findings pertaining to it, the intermediary determines the total allowable cost for the period of provider operations covered by the cost report and the total reasonable cost reimbursement due the provider for the services furnished during this period. When these determinations have been made, a final retroactive adjustment, if required, is made by the intermediary. In making a final adjustment, the intermediary reduces the payment by any monies owed the program by the provider (Pub. 15-1, § 2408.4).		

* As reported by Novitas. Subject to minor edits by Office of Counsel to the Inspector General.

† If the provider detected the error, the provider requested that Novitas reopen the cost report final settlement. If Novitas detected the error, Novitas initiated the reopening of the cost report final settlement.

‡ Novitas corrected overpayments/underpayments during the reopening of the final settlement.

APPENDIX C: NOVITAS SOLUTIONS, INC., COMMENTS

August 28, 2024

OFFICE OF AUDIT SERVICES, REGION VI
1100 COMMERCE STREET, ROOM 632
DALLAS, TX 75242

RE: A-06-23-05001

Novitas appreciates the opportunity to address the concerns presented by the Office of Inspector General in the report labeled *Novitas Solutions, Inc. Reopened and Corrected Cost Report Final Settlements with Obvious Errors to Collect Overpayments Made to Medicare Providers*. It is noteworthy to mention that Novitas was responsible for accurately reporting more than 10,000 NPR cost reports that were processed under Jurisdiction H and L (JH and JL) in their previous business periods.

As noted in OIG's report, Novitas identified and self-disclosed the errors that are mentioned. The reopenings were performed per the regulations to correct the errors identify by Novitas. It is also noteworthy to mention that three (HAC reduction and tentative settlement errors) of the ten reopenings make up $1.1 million of the $1.4 million in overpayments noted in this report. Thus, it is our opinion that the dollar impact on these errors is not an indication that these issues exist on a wider scale. We acknowledge the assessment performed by OIG and believe that we should continue to examine our supervisory review procedures to avoid and eliminate obvious errors.

The following are recommendations from OIG and Novitas' responses:

OIG Recommendation 1:
Develop and deliver additional education to auditors and audit supervisors regarding applicable criteria and review requirements.

MAC Response to Recommendation 1:
Novitas is in concurrence that we must continue to develop and deliver continuing education to auditors based on the needs and requirements identified by our training team, Audit staff, and CMS. As previously mentioned in the report, the issues cited were identified, self-disclosed, any money due to or from the program has been properly collected or paid by Novitas and have been part of past trainings and/or corrective actions. Moreover, these issues have been commonly addressed in CMS' QASP trainings and/or Novitas' internal trainings. Additionally, corrective actions were taken to address similar findings for reopenings based on results from

532 Riverside Avenue, Jacksonville, Florida 32202
Tel: 904-791-8760
Fax: 904-361-0466
www.novitas-solutions.com

our internal quality control (IQC) reviews. The corrective actions consisted of educating team members, improving processes, testing new processes, and implementing new processes. Each month our IQC team performs quality reviews on desk reviews, audits, and reopenings as part of our Quality Measurement Report (QMR) supplied to CMS. It is noteworthy to mention that we recently expanded the number of units selected for quality review to ensure a greater consistency in the quality of work. In addition, each month our IQC team provides high findings report from quality reviews to ensure audit team members are aware of issues, such as those identified in the OIG report, and they should be on the lookout for or know how to address as part desk reviews, audits, and reopenings being performed.

OIG Recommendation 2:
Develop and implement enhance procedures so that supervisors are better qualified to detect incorrect audit adjustments.

MAC Response to Recommendation 2:
Novitas is in concurrence with continuing to review and enhance its quality procedures to ensure staff are properly assigned reviews based on their level of expertise. Although Novitas has quality processes in place that should help avoid any obvious errors, we believe that there is a need to continuously examine our processes and procedures, and they are examined on an annual basis, as well as after IQC or QASP reviews where there are findings. It is noteworthy to mention that Novitas ensures that staff meet specific job requirements before they can progress to a higher level and begin performing supervisory review of work in order to detect incorrect audit adjustments. For consistency, our Perform Supervisory Review of Desk Review Procedure establishes the expectations of auditors performing supervisory reviews. Also, as part of our desk review and final settlement process, Novitas uses a quality checklist to ensure the minimum quality expectations have been performed, which includes a verification of all adjustments. Additionally, since this report was issued, Novitas has also implemented a process to perform verification of the adjustments against the electronic files, used to generate the final cost report, prior to issuing a final settlement.

In conclusion, Novitas acknowledges the issues and recommendations mentioned in the report by OIG and will continue to look for ways to improve the work we do. We are thankful for OIG's willingness to work with us, share their recommendations, provide us an opportunity to offer our responses to this matter, and allow us to take any action needed to better our processes. We will continue to examine our review processes and procedures to be the best version of ourselves.

Sincerely,

Deborah A Taylor Digitally signed by Deborah A Taylor
Date: 2024.08.28 15:48:08 -04'00'

Deborah Taylor
Vice President & COO
Novitas Solutions, Inc.