

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**PINNACLE BUSINESS SOLUTIONS  
DID NOT ALWAYS REFER MEDICARE  
COST REPORTS AND RECONCILE  
OUTLIER PAYMENTS**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



**Gloria L. Jarmon  
Deputy Inspector General  
for Audit Services**

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# *Office of Inspector General*

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## EXECUTIVE SUMMARY

*Pinnacle Business Solutions did not always refer cost reports whose outlier payments qualified for reconciliation to the Centers for Medicare & Medicaid Services. The net financial impact of these unreferred cost reports was approximately \$1.4 million that should be recouped from health care providers and returned to Medicare. In addition, Pinnacle did not always reconcile the outlier payments associated with cost reports whose outlier payments qualified for reconciliation.*

### WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) implemented inpatient outlier regulations in 2003 that authorized Medicare contractors to reconcile outlier payments before the settlement of certain hospital cost reports to ensure that these payments reflected the actual costs that each hospital had incurred. CMS policy stated that if a hospital's cost report met specified criteria for reconciliation, the Medicare contractor should refer it to CMS for reconciliation of outlier payments. Effective April 2011, CMS gave Medicare contractors the responsibility to perform reconciliations upon receipt of authorization from the CMS Central Office.

This review is one of a series of reviews to determine whether Medicare contractors had (1) referred the cost reports that qualified for reconciliation and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility. One such contractor, Pinnacle Business Solutions (Pinnacle), was the Medicare contractor for Arkansas, Louisiana, and Mississippi. In November 2012, Pinnacle's responsibilities transitioned to Novitas Solutions, Inc.; accordingly, we are addressing our recommendations to Novitas.

The objectives of this review were to determine whether Pinnacle (1) referred cost reports to CMS for reconciliation in accordance with Federal guidelines and (2) reconciled the outlier payments associated with the referred cost reports by December 31, 2011.

### BACKGROUND

CMS administers Medicare and uses a prospective payment system to pay Medicare-participating hospitals (hospitals) for providing inpatient hospital services to Medicare beneficiaries. CMS uses Medicare contractors to, among other things, process and pay Medicare claims submitted for medical services.

Medicare supplements basic prospective payments for inpatient hospital services by making outlier payments, which are designed to protect hospitals from excessive losses due to unusually high-cost cases. Medicare contractors calculate outlier payments on the basis of claim submissions made by hospitals and by using hospital-specific cost-to-charge ratios. Medicare contractors review cost reports that hospitals have submitted, make any necessary adjustments, and determine whether payment is owed to Medicare or to the hospital. In general, a settled cost report may be reopened by the Medicare contractor no more than 3 years after the date of the final settlement of that cost report. We refer to this as the 3-year reopening limit.

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether Pinnacle had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.

## **WHAT WE FOUND**

Of 23 cost reports with outlier payments that qualified for reconciliation, Pinnacle referred 12 cost reports to CMS in accordance with Federal guidelines. However, Pinnacle did not refer 11 cost reports that should have been referred to CMS for reconciliation. Of these, four cost reports had not been settled and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the difference between (1) the outlier payments associated with two of these four cost reports and (2) the recalculated outlier payments totaled at least \$3,073,552. We refer to this difference as financial impact. We also calculated that \$1,714,952 was due from Medicare to providers for the other two cost reports of the four that should have been referred to CMS for reconciliation. The net financial impact of the outlier payments associated with these four unreferred cost reports was therefore at least \$1,358,600 that was due to Medicare. The seven remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation; the financial impact of the outlier payments associated with those seven cost reports totaled \$5,913,993.

Of the 12 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Pinnacle had not reconciled the outlier payments associated with any of these cost reports by December 31, 2011. Ten of the twelve cost reports were within the 3-year reopening limit. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 8 of the 12 cost reports that were referred but not reconciled was at least \$8,598,266. We also calculated that \$1,165,150 was due from Medicare to providers for 2 of the 12 cost reports that were referred but not reconciled. For the remaining two cost reports that exceeded the 3-year reopening limit and should have been reconciled, the financial impact of the outlier payments totaled \$291,660 that may be due from Medicare to providers. The net financial impact of the outlier payments associated with these 12 cost reports that were referred but not reconciled was therefore at least \$7,141,456 that was due to Medicare.

Because certain claims require specialized recalculations for their outlier payments, we were unable to recalculate 5 of the 2,649 claims associated with the cost reports that we were recalculating and are setting aside \$184,616 in outlier payments associated with those claims for resolution by Novitas and CMS.

## **WHAT WE RECOMMEND**

We recommend that Novitas:

- review the 4 cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, and request CMS approval to:

- recoup \$3,073,552 in funds and associated interest from health care providers (two cost reports) and refund that amount to the Federal Government and
- return \$1,714,952 in funds and associated interest from Medicare to providers (two cost reports);
- review the 7 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not; determine whether these cost reports may be reopened; and work with CMS to resolve \$5,913,993 in funds and associated interest from health care providers that may be due to the Federal Government;
- review the 10 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
  - reconcile the \$8,598,266 in associated outlier payments due to the Federal Government (8 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and
  - reconcile the \$1,165,150 in associated outlier payments due from Medicare to providers (2 cost reports), finalize these cost reports, and return the funds to the providers;
- review the 2 cost reports that had exceeded the 3-year reopening limit, were referred to CMS, and should have been reopened but were not; determine whether these cost reports may be reopened; and work with CMS to resolve the \$291,660 in funds and associated interest that may be due from Medicare to health care providers;
- work with CMS to resolve the \$184,616 in outlier payments associated with the five claims that we could not recalculate;
- ensure that control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;
- ensure that policies and procedures are in place so that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and
- review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

## **AUDITEE COMMENTS AND OUR RESPONSE**

In written comments on our draft report, Novitas concurred with all of our recommendations and described corrective actions that it had taken or planned to take.

In response to our second and fourth recommendations—regarding cost reports that were settled and had exceeded the 3-year reopening limit—Novitas said that it could not reopen seven of the nine cost reports because of CMS instructions. For the remaining two cost reports, Novitas said that it would complete appropriate corrective actions.

After submitting its written comments and in response to a followup query from us, Novitas informed us that it could not reopen any of the nine cost reports that had exceeded the 3-year reopening limit.

After reviewing Novitas’s comments, we maintain that all of our findings and recommendations remain valid. With respect to the nine cost reports associated with our second and fourth recommendations, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of “similar fault.”

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## INTRODUCTION

### WHY WE DID THIS REVIEW

The Centers for Medicare & Medicaid Services (CMS) implemented inpatient outlier regulations in 2003 that authorized Medicare contractors to reconcile outlier payments before the settlement of certain hospital cost reports to ensure that these payments reflected the actual costs that each hospital had incurred. CMS policy stated that if a hospital's cost report met specified criteria for reconciliation, the Medicare contractor should refer it to CMS for reconciliation of outlier payments.<sup>1</sup> Effective April 2011, CMS gave Medicare contractors the responsibility to perform reconciliations upon receipt of authorization from the CMS Central Office.

In a previous Office of Inspector General (OIG) audit, we reported to CMS that 292 cost reports referred by 9 Medicare contractors for reconciliation had not been settled.<sup>2</sup> In that audit we reviewed outlier cost report data submitted to CMS by 9 selected Medicare contractors that served a total of 15 jurisdictions during our audit period (October 1, 2003, through December 31, 2008). To follow up on that audit, we performed a series of reviews to determine whether the Medicare contractors had (1) referred the cost reports that qualified for reconciliation (a responsibility that already rested with the contractors) and (2) reconciled outlier payments in accordance with the April 2011 shift in responsibility. One such contractor, Pinnacle Business Solutions (Pinnacle), was the Medicare contractor for Arkansas, Louisiana, and Mississippi. In November 2012, Pinnacle's responsibilities transitioned to Novitas Solutions, Inc.; accordingly, we are addressing our recommendations to Novitas.

### OBJECTIVES

Our objectives were to determine whether Pinnacle (1) referred cost reports to CMS for reconciliation in accordance with Federal guidelines and (2) reconciled the outlier payments associated with the referred cost reports by December 31, 2011.<sup>3</sup>

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<sup>1</sup> Although CMS did not instruct Medicare contractors to refer hospitals in need of reconciliation until 2005, the instructions applied to cost reporting periods beginning on or after October 1, 2003. Moreover, CMS's instructions during this period changed the responsibility for performing reconciliations. CMS Transmittal A-03-058 (Change Request 2785; July 3, 2003) instructed Medicare contractors to perform reconciliations. Later, Transmittal 707 (Change Request 3966; October 12, 2005) specified that CMS would perform reconciliations.

<sup>2</sup> *The Centers for Medicare & Medicaid Services Did Not Reconcile Medicare Outlier Payments in Accordance With Federal Regulations and Guidance* (A-07-10-02764), issued June 28, 2012.

<sup>3</sup> Although the CMS-established deadline for reconciling the cost reports was October 1, 2011, for this review we provided a 3-month grace period by establishing December 31, 2011, as our cutoff date.

## **BACKGROUND**

### **Medicare and Outlier Payments**

Under Title XVIII of the Social Security Act (the Act), Medicare provides health insurance for people aged 65 and over, people with disabilities, and people with permanent kidney disease. CMS administers the program and uses a prospective payment system (PPS) to pay Medicare-participating hospitals (hospitals) for providing inpatient hospital services to Medicare beneficiaries. CMS uses Medicare contractors to, among other things, process and pay Medicare claims submitted for medical services.

Medicare supplements basic prospective payments for inpatient hospital services by making outlier payments, which are designed to protect hospitals from excessive losses due to unusually high-cost cases (the Act, § 1886(d)(5)(A)). Medicare contractors calculate outlier payments on the basis of claim submissions made by hospitals and by using hospital-specific cost-to-charge ratios (CCRs).

Under CMS requirements that became effective in 2003, Medicare contractors were to refer hospitals' cost reports to CMS (cost report referral) for reconciliation of outlier payments (reconciliation) to correctly re-price submitted claims and settle cost reports. In December 2010, CMS stated that it had not performed reconciliations because of system limitations and directed the Medicare contractors to perform backlogged reconciliations (effective April 1, 2011), as well as all future reconciliations.

For this review, we focused on one of the 2003 requirements: to reconcile outlier payments before the final settlement of hospital cost reports to ensure that these payments are an accurate assessment of the actual costs incurred by each hospital.

### **Hospital Outlier Payments, Medicare Cost Report Submission, and Settlement Process**

To qualify for outlier payments, a claim must have costs that exceed a CMS-established cost threshold. Costs are calculated by multiplying covered charges by a hospital-specific CCR. Because a hospital's actual CCR for any given cost-reporting period cannot be known until final settlement of the cost report for that year, the Medicare contractors calculate and make outlier payments using the most current information available when processing a claim. For discharges occurring on or after October 1, 2003, the CCR applied at the time a claim is processed is based on either the most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period (42 CFR § 412.84(i)(2)). More than one CCR can be used in a cost reporting period.

A hospital must submit its cost reports, which can include outlier payments, to Medicare contractors within 5 months after the hospital's fiscal year ends. CMS instructs a Medicare contractor to determine acceptability within 30 days of receipt of a cost report (*Provider Reimbursement Manual*, part 2, § 140). After accepting a cost report,<sup>4</sup> the Medicare contractor

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<sup>4</sup> Medicare contractors do not accept every cost report on its initial submission. Medicare contractors can return cost reports to hospitals for correction, additional information, or other reasons.

completes its preliminary review and may issue a tentative settlement to the hospital. In general, Medicare contractors perform tentative settlements to make partial payments to hospitals owed Medicare funds (although in some cases a tentative settlement may result in a payment from a hospital to Medicare). This practice helps ensure that hospitals are not penalized because of possible delays in the final settlement process.

After accepting a cost report—and regardless of whether it has brought that report to final settlement—the Medicare contractor forwards it to CMS, which maintains submitted cost reports in a database. We used this database in our analysis for this review.

The Medicare contractor reviews the cost report and may audit it before final settlement. If a cost report is audited, the Medicare contractor incorporates any necessary adjustments to identify reimbursable amounts and finalize Medicare reimbursements due from or to the hospital.<sup>5</sup> At the end of this process, the Medicare contractor issues the final settlement document, the Notice of Program Reimbursement (NPR), to the hospital. The NPR shows whether payment is owed to Medicare or to the hospital. The final settlement thus incorporates any audit adjustments the Medicare contractor may have made.

In general, a settled cost report may be reopened by the Medicare contractor no more than 3 years<sup>6</sup> after the date of the final settlement of that cost report (42 CFR § 405.1885(b)). We refer to this as the 3-year reopening limit.

Outlier payments may under certain circumstances be reconciled so that submitted claims can be correctly re-priced before final settlement of a cost report. For this review, we considered the outlier payments associated with a cost report to have been reconciled and the reconciliation process to have been complete if all claims had been correctly re-priced and the cost report itself had been brought to final settlement.

## **CMS Changes in the Hospital Outlier Payment Reconciliation Methodology**

### *Outlier Payment Reconciliation*

CMS developed new outlier regulations<sup>7</sup> and guidance in 2003 after reporting that, from Federal fiscal years 1998 through 2002, it paid approximately \$9 billion more in Medicare inpatient PPS

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<sup>5</sup> Among other reasons, cost reports may be adjusted to reflect actual expenses incurred or to make allowances for recovery of expenses through sales or fees.

<sup>6</sup> Cost reports may be reopened by Medicare contractors beyond 3 years for fraud or similar fault (42 CFR § 405.1885(b)(3); *Provider Reimbursement Manual*, part 1, § 2931.1 (F)).

<sup>7</sup> CMS, *Medicare Program; Change in Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) Under the Acute Care Hospital Inpatient and Long-Term Care Hospital [LTCH] Prospective Payment Systems*, 68 Fed. Reg. 34494 (Jun. 9, 2003).

(IPPS) outlier payments than it had projected.<sup>8,9</sup> The 2003 regulations intended to ensure that outlier payments were limited to extraordinarily high-cost cases and that final outlier payments reflected an accurate assessment of the actual costs the hospital had incurred. Medicare contractors were to refer hospitals' cost reports to CMS for reconciliation so CMS could correctly re-price submitted claims and allow Medicare contractors to settle cost reports.<sup>10</sup>

### *Reconciliation Process*

After the end of the cost reporting period, the hospital compiles the cost report from which the actual CCR for that cost reporting period can be computed. The actual CCR may be different than the CCR from the most recently settled or most recent tentative settled cost report that was used to calculate individual outlier claim payments during the cost reporting period. If a hospital's total outlier payments during the cost reporting period exceed \$500,000 and the actual CCR is found to be plus or minus 10 percentage points of the CCR used during that period to calculate outlier payments, CMS policy requires the Medicare contractor to refer the hospital's cost report to CMS for reconciliation (*Medicare Claims Processing Manual (Claims Processing Manual)*, chapter 3, § 20.1.2.5). For this report, we refer to the process of determining whether a cost report qualifies for referral as the "reconciliation test."

If the criteria for reconciliation are not met, the Medicare contractor finalizes the cost report and issues an NPR to the hospital. If these criteria are met, the Medicare contractor refers the cost report to CMS at both the central and regional levels.

CMS Transmittal 707<sup>11</sup> provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations. This assignment of responsibility remained in effect until April 1, 2011. In CMS Transmittal 2111,<sup>12</sup> CMS directs the Medicare contractors to assume the responsibility to perform the reconciliations effective April 1, 2011. CMS Transmittal 2111 also says that contractors should perform reconciliations only if they receive prior approval from CMS. In that document, CMS also states that it had not performed reconciliations because of system limitations.

To process the backlog of cost reports requiring reconciliation, CMS instructed Medicare contractors to submit to CMS, between April 1 and April 25, 2011, a list of hospitals whose cost

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<sup>8</sup> CMS Transmittal A-03-058 (Change Request 2785; July 3, 2003).

<sup>9</sup> CMS had projected that it would pay approximately \$17.6 billion for Medicare IPPS outlier payments but actually made approximately \$26.6 billion in payments.

<sup>10</sup> Although CMS did not instruct Medicare contractors to refer hospital cost reports in need of reconciliation until 2005, the 2003 regulations were applicable to cost reporting periods beginning on or after October 1, 2003.

<sup>11</sup> CMS, "IPPS Outlier Reconciliation," Claims Processing Manual, Pub. No. 100-04, Transmittal 707 (Change Request 3966; October 12, 2005).

<sup>12</sup> CMS, *Outlier Reconciliation and Other Outlier Manual Updates for IPPS, OPSS [Outpatient PPS], IRF [Inpatient Rehabilitation Facility] PPS, IPF [Inpatient Psychiatric Facility] PPS and LTCH PPS*, Claims Processing Manual, Transmittal 2111 (Change Request 7192; December 3, 2010).

reports had been flagged for reconciliation<sup>13</sup> before April 1, 2011. Further, CMS was to grant approval for Medicare contractors to perform reconciliations for those hospitals with open cost reports. Contractors were then to reconcile, by October 1, 2011, outlier claims that had been flagged before April 1, 2011.

### **CMS Lump Sum Utility Used in Outlier Recalculation**

Specialized software exists to help Medicare contractors perform reconciliations and process cost reports. Medicare contractors use the Fiscal Intermediary Standard System (FISS) Lump Sum Utility to perform the reconciliations. The FISS Lump Sum Utility calculates the difference between the original and revised PPS payment amounts and generates a report to CMS. Delays in software updates to the FISS Lump Sum Utility can prevent Medicare contractors from recalculating the outlier payments.

### **Cost Reports on Hold**

In August 2008, CMS instructed Medicare contractors to hold for settlement, rather than settle, any cost reports affected by revised Supplemental Security Income (SSI) ratios. In addition, CMS instructed Medicare contractors to stop issuing final settlements on cost reports using the fiscal years 2006 and 2007 SSI ratios in the calculation of disproportionate share hospital (DSH) payments. CMS subsequently expanded the “DSH/SSI hold” to include cost reports using the fiscal years 2008 and 2009 SSI ratios. The DSH/SSI hold remained in effect until CMS published the updated SSI ratios in June 2012.

### **HOW WE CONDUCTED THIS REVIEW**

We compared records from CMS’s database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether Pinnacle had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011. If the cost reports had not been reconciled by December 31, 2011, we determined the status of the cost reports as of that date and, where necessary, used CMS’s database to calculate the amounts due to Medicare or to providers.

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 details of our audit scope and methodology.

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<sup>13</sup> CMS uses the term “flagged” to refer to outlier payments whose reconciliations were backlogged between 2005 and April 1, 2011.

## FINDINGS

Of 23 cost reports with outlier payments that qualified for reconciliation, Pinnacle referred 12 cost reports to CMS in accordance with Federal guidelines. However, Pinnacle did not refer 11 cost reports that should have been referred to CMS for reconciliation. Of these, four cost reports had not been settled and should have been referred to CMS for reconciliation. We calculated that as of December 31, 2011, the difference between (1) the outlier payments associated with two of these four cost reports and (2) the recalculated outlier payments totaled at least \$3,073,552. We refer to this difference as financial impact.<sup>14</sup> We also calculated that \$1,714,952 was due from Medicare to providers for the other two cost reports of the four that should have been referred to CMS for reconciliation. The net financial impact of the outlier payments associated with these four unrefereed cost reports was therefore at least \$1,358,600 that was due to Medicare. The seven remaining cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation; the financial impact of the outlier payments associated with those seven cost reports totaled \$5,913,993.

Of the 12 cost reports that were referred to CMS with outlier payments that qualified for reconciliation, Pinnacle had not reconciled the outlier payments associated with any of these cost reports by December 31, 2011. Ten of the twelve cost reports were within the 3-year reopening limit. We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with 8 of the 12 cost reports that were referred but not reconciled was at least \$8,598,266. We also calculated that \$1,165,150 was due from Medicare to providers for 2 of the 12 cost reports that were referred but not reconciled. For the remaining two cost reports that exceeded the 3-year reopening limit and should have been reconciled, the financial impact of the outlier payments totaled \$291,660 that may be due from Medicare to providers. The net financial impact of the outlier payments associated with these 12 cost reports that were referred but not reconciled was therefore at least \$7,141,456 that was due to Medicare.

Because certain claims require specialized recalculations for their outlier payments, we were unable to recalculate 5 of the 2,649 claims associated with the cost reports that we were recalculating and are setting aside \$184,616<sup>15</sup> in outlier payments associated with those claims for resolution by Novitas and CMS.

See Appendix B for a summary of the status of the 23 cost reports with respect to referral and reconciliation, as well as the associated dollar amounts due to Medicare or to providers.

## FEDERAL REQUIREMENTS

Federal regulations state that for discharges occurring on or after October 1, 2003, the CCR applied at the time a claim is processed (and outlier payments are made) is based on either the

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<sup>14</sup> The financial impacts that we convey in this report take the time value of money into account and thus also include any accrued interest; see also Appendix A.

<sup>15</sup> This amount is separate from the financial impact amounts mentioned in the two immediately preceding paragraphs.

most recent settled cost report or the most recent tentative settled cost report, whichever is from the latest cost reporting period (42 CFR § 412.84(i)(2)).

If a hospital's total outlier payments during the cost reporting period exceed \$500,000 and the actual CCR is found to be plus or minus 10 percentage points of the CCR used during that period to calculate outlier payments, CMS policy requires the Medicare contractor to refer the hospital's cost report to CMS for reconciliation (Claims Processing Manual, chapter 3, § 20.1.2.5).

CMS Transmittal 707 provided instructions on the reconciliation process and stated that CMS was to perform the reconciliations. This assignment of responsibility remained in effect until April 1, 2011. In CMS Transmittal 2111, CMS directs the Medicare contractors to assume the responsibility to perform the reconciliations effective April 1, 2011, although the CMS Central Office would determine whether reconciliations would be performed. In this document, CMS also states that it had not performed reconciliations because of system limitations.

Our calculations of the financial impact of the findings developed in this audit took into account the time value of money. Federal regulations for discharges occurring on or after August 8, 2003, state that outlier payments may be adjusted at the time of reconciliation to account for the time value of any underpayments or overpayments (42 CFR § 412.84(m)). The provisions of the Claims Processing Manual that were in effect during our audit period provided guidance on how to apply the time value of money to the reconciled outlier dollar amount. Specifically, these provisions state that the time value of money stops accruing on the day that the CMS Central Office receives notification of a cost report referral from a Medicare contractor (Claims Processing Manual, chapter 3, § 20.1.2.6).

## **COST REPORTS NOT REFERRED**

Of 23 cost reports with outlier payments that qualified for reconciliation, Pinnacle referred 12 cost reports to CMS in accordance with Federal guidelines. However, Pinnacle did not refer 11 cost reports that should have been referred to CMS for reconciliation.

### **Cost Reports Within the 3-Year Reopening Limit**

Of the 11 cost reports that Pinnacle did not refer to CMS for reconciliation, 4 had not been settled and should have been referred to CMS for reconciliation. Pinnacle did not refer the four cost reports to CMS because Pinnacle had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified and referred to CMS.<sup>16</sup> As a result of the inadequacy of these control procedures:

- Pinnacle did not perform the reconciliation test to identify and refer two cost reports that qualified for reconciliation and
- Pinnacle did not refer two other cost reports that qualified for reconciliation even though Pinnacle correctly performed the reconciliation test and recognized that they qualified for reconciliation.

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<sup>16</sup> All four of these cost reports were also on hold because of the SSI-related litigation discussed in "Background."

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these four unreferrred cost reports totaled at least \$3,073,552 that was due to Medicare (two cost reports) and \$1,714,952 that was due to providers (two cost reports).<sup>17</sup>

### **Cost Reports Outside the 3-Year Reopening Limit**

Of the 11 cost reports that Pinnacle did not refer to CMS for reconciliation, the remaining 7 cost reports had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation. Pinnacle did not refer the seven cost reports to CMS because Pinnacle had not established adequate control procedures to ensure that all cost reports whose outlier payments qualified for reconciliation were correctly identified; were referred to CMS; and, if necessary, were reopened before the 3-year reopening limit. As a result of the inadequacy of these control procedures:

- Pinnacle did not perform the reconciliation test to identify and refer three cost reports that qualified for reconciliation,
- Pinnacle did not correctly perform the reconciliation test for two cost reports and incorrectly concluded that those cost reports did not meet the criteria for reconciliation, and
- Pinnacle did not refer two other cost reports that qualified for reconciliation even though Pinnacle correctly performed the reconciliation test and recognized that they qualified for reconciliation.

We calculated that as of December 31, 2011, the financial impact of the outlier payments associated with these seven cost reports totaled at least \$5,913,993 that may be due to Medicare.

### **Claims That Could Not Be Recalculated**

The 11 cost reports that were not referred included 2 claims with \$49,719 in associated outlier payments. We were unable to recalculate these claims because they required specialized recalculations for their outlier payments. We are therefore setting aside the \$49,719 for resolution by Novitas and CMS. We are separately providing detailed data on the claims that we could not recalculate to Novitas.

### **COST REPORTS REFERRED BUT OUTLIER PAYMENTS NOT RECONCILED**

Of the 12 referred cost reports whose outlier payments qualified for reconciliation, Pinnacle did not reconcile the outlier payments associated with any of these cost reports by December 31, 2011.

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<sup>17</sup> As stated in "Findings," the net financial impact of the outlier payments associated with these four unreferrred cost reports was therefore at least \$1,358,600 that was due to Medicare.

### **Cost Reports Within the 3-Year Reopening Limit**

Of the 12 referred cost reports whose outlier payments qualified for reconciliation, 10 had not been settled or were settled and reopened within the 3-year reopening limit; the outlier payments associated with these 10 cost reports should have been reconciled. The statuses of these cost reports with unreconciled outlier payments were as follows:

- 2 cost reports were on hold because CMS had not calculated revised SSI ratios,
- 1 cost report was on hold because CMS had not calculated revised SSI ratios and because of pending updates to the FISS Lump Sum Utility software that prevented the recalculation of outlier payments, and
- 7 cost reports had been correctly referred but were still being processed before final settlement (2 cost reports were awaiting CMS approval to reconcile the outlier payments, 1 had received CMS approval and was undergoing the reconciliation process, and 4 were pending updates to the FISS Lump Sum Utility software).

For the two cost reports that had received CMS approval and were undergoing the reconciliation process, Pinnacle's policies and procedures did not ensure that it reconciled all outlier payments associated with all referred cost reports that qualified for reconciliation in accordance with Federal guidelines. For the other nine cost reports that were referred but whose outlier payments had not been reconciled, CMS bore principal responsibility for the delays that we have described above.<sup>18</sup>

For the 10 referred cost reports whose outlier payments Pinnacle did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least \$8,598,266 that was due to Medicare (8 cost reports) and \$1,165,150 that was due to providers (2 cost reports).

### **Cost Reports Outside the 3-Year Reopening Limit**

Of the 12 referred cost reports whose outlier payments qualified for reconciliation, the remaining 2 cost reports were brought to final settlement without their outlier payments being reconciled. These two cost reports went beyond the 3-year reopening limit without being reopened. Pinnacle did not reconcile these two cost reports because its policies and procedures did not ensure that it reopened all referred cost reports and reconciled all associated outlier payments in accordance with Federal guidelines. For the two cost reports that exceeded the 3-year reopening limit and whose outlier payments Pinnacle did not reconcile by December 31, 2011, the financial impact of the outlier payments was at least \$291,660 that may be due to providers.<sup>19</sup>

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<sup>18</sup> We will report separately to CMS on issues related to cost report referral and outlier payment reconciliation in a future review.

<sup>19</sup> As stated in "Findings," the net financial impact of the outlier payments associated with the 12 cost reports that were referred but not reconciled (both cost reports that were within the 3-year reopening limit and those that were outside the 3-year reopening limit) was therefore at least \$7,141,456 that was due to Medicare.

## **Claims That Could Not Be Recalculated**

The 12 cost reports with unreconciled outlier payments included 3 claims with \$134,897 in associated outlier payments. We were unable to recalculate these claims because they required specialized recalculations for their outlier payments. We are therefore setting aside the \$134,897 for resolution by Novitas and CMS. We are separately providing detailed data on the claims that we could not recalculate to Novitas.

## **FINANCIAL IMPACT TO MEDICARE**

As of December 31, 2011, the financial impact of the outlier payments associated with the four unREFERRED cost reports that were within the 3-year reopening limit was at least \$3,073,552 that was due to Medicare (two cost reports) and \$1,714,952 that was due to providers (two cost reports). These cost reports should have been referred to CMS for reconciliation but were not and were also not reconciled even though their outlier payments qualified for reconciliation.

Also as of December 31, 2011, the financial impact of the outlier payments associated with the seven cost reports that exceeded the 3-year reopening limit and that should have been referred to CMS for reconciliation but were not was at least \$5,913,993 that may be due to Medicare.

In addition, for the 10 referred cost reports that were within the 3-year reopening limit and whose outlier payments Pinnacle did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least \$8,598,266 that was due to Medicare (8 cost reports) and \$1,165,150 that was due to providers (2 cost reports). Therefore, the net financial impact to Medicare of the 10 cost reports that were within the 3-year reopening limit with unreconciled outlier payments was at least \$7,433,116.

Finally, for the two referred cost reports that exceeded the 3-year reopening limit and whose outlier payments Pinnacle did not reconcile by December 31, 2011, the financial impact of those outlier payments was at least \$291,660 that may be due to providers.

## **RECOMMENDATIONS**

We recommend that Novitas:

- review the 4 cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, and request CMS approval to:
  - recoup \$3,073,552 in funds and associated interest from health care providers (two cost reports) and refund that amount to the Federal Government and
  - return \$1,714,952 in funds and associated interest from Medicare to providers (two cost reports);

- review the 7 cost reports that had been settled, had exceeded the 3-year reopening limit, and should have been referred to CMS for reconciliation but were not; determine whether these cost reports may be reopened; and work with CMS to resolve \$5,913,993 in funds and associated interest from health care providers that may be due to the Federal Government;
- review the 10 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:
  - reconcile the \$8,598,266 in associated outlier payments due to the Federal Government (8 cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and
  - reconcile the \$1,165,150 in associated outlier payments due from Medicare to providers (2 cost reports), finalize these cost reports, and return the funds to the providers;
- review the 2 cost reports that had exceeded the 3-year reopening limit, were referred to CMS, and should have been reopened but were not; determine whether these cost reports may be reopened; and work with CMS to resolve the \$291,660 in funds and associated interest that may be due from Medicare to health care providers;
- work with CMS to resolve the \$184,616 in outlier payments associated with the five claims that we could not recalculate;
- ensure that control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified; referred; and, if necessary, reopened before the 3-year reopening limit;
- ensure that policies and procedures are in place so that it reconciles all outlier payments associated with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines; and
- review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

### **AUDITEE COMMENTS**

In written comments on our draft report, Novitas concurred with all of our recommendations and described corrective actions that it had taken or planned to take. Specifically, Novitas said that it would work to address the proper settlement of the cost reports (both unsettled and settled) that were within the 3-year reopening limit (in our first recommendation). For our third recommendation, Novitas stated that it would review the 10 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation, that it would work with CMS to reconcile the cost reports, and that it would complete appropriate corrective actions.

For the nine cost reports (seven in our second recommendation and two in our fourth recommendation) that were settled and had exceeded the 3-year reopening limit, Novitas said that it could not reopen seven of them because, in accordance with CMS instructions in the *Provider Reimbursement Manual*, those cost reports had exceeded the 3-year reopening limit and, therefore, could not be reopened. For the two remaining cost reports (of the nine), Novitas said that it would complete appropriate corrective actions.

After submitting its written comments, and in response to a followup query from us, Novitas informed us that it could not reopen any of the nine cost reports that had exceeded the 3-year reopening limit.

For our fifth recommendation, Novitas stated that it would work with CMS to address the \$184,616 in outlier payments associated with the five claims that we could not recalculate and that it would complete appropriate corrective actions.

For our sixth and seventh recommendations, Novitas said that it had revised its procedures related to the outlier reconciliation process.

For our final recommendation, Novitas stated that it would review cost reports submitted since the end of the audit period and added that it would refer and reconcile those cost reports that meet the outlier reconciliation criteria in accordance with Federal guidelines.

Novitas's comments appear in their entirety as Appendix C.

## **OFFICE OF INSPECTOR GENERAL RESPONSE**

After reviewing Novitas's comments, we maintain that all of our findings and recommendations remain valid.

With respect to the nine cost reports associated with our second and fourth recommendations, CMS regulations allow for cost reports to be reopened beyond 3 years if there is evidence of "similar fault." Specifically, 42 CFR § 405.1885(b)(3) provides that a Medicare payment contractor (e.g., Novitas) may reopen an initial determination *at any time* if the determination was procured by fraud or similar fault. For example, a Medicare payment contractor may reopen a cost report after finding that a provider received money that it knew or reasonably should have known it was not entitled to retain (73 Fed. Reg. 30190, 30233 (May 23, 2008)). Because the outlier reconciliation rules are promulgated in Federal regulations as noted in this report, providers knew or should have known the rules when their cost reports were settled. We believe that these regulations constitute a sufficient basis for our second and fourth recommendations and recognize that ultimately, CMS as the cognizant Federal agency has the authority to decide how to resolve these and the other recommendations in this audit report. Accordingly, we continue to recommend that Novitas determine whether these providers (associated with seven unreferral cost reports and two referred but not reconciled cost reports) procured Medicare funds by "similar fault" and work with CMS to resolve their \$6,205,653 (\$5,913,993 + \$291,660) in outlier payments.

After receiving Novitas's comments, we gave Novitas the supporting documentation associated with the five claims that we could not recalculate and that are the basis of our fifth recommendation.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

We compared records from CMS's database to information received from Medicare contractors for cost reports that included medical services provided between October 1, 2003, and December 31, 2008, to determine whether Pinnacle had referred cost reports to CMS for reconciliation in accordance with Federal guidelines. We also determined whether cost reports that qualified for referral to CMS had been reconciled by December 31, 2011.<sup>20</sup> If the cost reports had not been reconciled by December 31, 2011, we determined the status of the cost reports as of that date and calculated the amounts due to Medicare or to providers.

We performed audit work in our Denver, Colorado, field office, from October 2011 to July 2013.

### METHODOLOGY

To accomplish our objectives, we:

- reviewed applicable Federal requirements and CMS guidance;
- held discussions with CMS officials to gain an understanding of CMS requirements and guidance furnished to Pinnacle and other Medicare contractors concerning the reconciliation process and responsibilities;
- obtained from CMS a list of cost reports that Medicare contractors had referred for reconciliation;
- held discussions with Pinnacle officials to gain an understanding of the cost report process, outlier reconciliation tests, and cost report referrals to CMS;
- reviewed Pinnacle's policies and procedures regarding referral to CMS and reconciliation of cost reports;
- reviewed provider lists from all Medicare contractors to determine which providers were under Pinnacle's jurisdiction as of October 12, 2011 (the start of our audit), and as of August 1, 2012;
- obtained and reviewed the list of cost reports, with supporting documentation, that Pinnacle had referred to CMS for reconciliation during our audit period;
- obtained the cost report data from CMS's database for cost reports with fiscal-year ends during our audit period;

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<sup>20</sup> Although the CMS-established deadline for reconciling the cost reports was October 1, 2011, for this review we provided a 3-month grace period by establishing December 31, 2011, as our cutoff date.

- obtained the Inpatient Acute Care and LTCH provider specific files (PSFs) from the CMS Web site;
- determined which cost reports qualified for reconciliation by:
  - using the information in a CMS database to identify acute-care and long-term-care cost reports that had greater than \$500,000 in outlier payments<sup>21</sup> and
  - using the information in CMS’s database and PSF data to calculate and compare the actual and weighted average CCRs to determine whether the resulting variance was greater than 10 percentage points;
- verified that Pinnacle used the three different types of outlier payments specified by Federal regulations<sup>22</sup> (short-stay, operating, and capital) to determine whether the cost reports qualified for reconciliation;
- requested that Pinnacle provide a status update and recalculated outlier payment amounts (if applicable) for all cost reports that qualified for reconciliation;<sup>23</sup>
- reviewed Pinnacle’s response and categorized the cost reports according to their respective statuses;
- verified whether Pinnacle had referred the cost reports before the date of the audit notification letter;
- verified that all of the cost reports we reviewed met the criteria for reconciliation;
- performed the following actions for cost reports that qualified for outlier reconciliation but for which Pinnacle did not recalculate the outlier payments:
  - obtained the detailed Provider Statistical & Reimbursement reports from Pinnacle or obtained the National Claims History data from CMS;
  - verified the original outlier payments using the CCR that was used to pay the claim;<sup>24</sup>

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<sup>21</sup> CMS cost report data included operating and capital payments but did not include short-stay outlier payments.

<sup>22</sup> Claims Processing Manual, chapter 3, § 20.1.2.5.

<sup>23</sup> Our count of cost reports that qualified for outlier reconciliation included those that met the reconciliation test and those that were referred by Pinnacle.

<sup>24</sup> We set aside claims whose original outlier payments we could not verify.

- recalculated the outlier payment amounts for those cost reports that Pinnacle did not recalculate using the actual CCRs;
  - identified those claims that we were unable to recalculate either because we could not verify the original outlier payment calculation for particular claims, because the claims were for providers that required specialized recalculations, or because some of the CCRs from the CMS database were so anomalous as to be of questionable reliability; and
  - calculated accrued interest<sup>25</sup> as of the date that the cost report was referred to CMS (for unreferred cost reports or those that were referred after December 31, 2011, we calculated the amount of accrued interest as of December 31, 2011);
- summarized the results of our analysis including the total amount due to or from Medicare; and
  - provided the results of our review to Novitas officials on July 9, 2013.

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.

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<sup>25</sup> We calculated interest by referring to the Claims Processing Manual, § 20.1.2.6.

**APPENDIX B: SUMMARY OF AMOUNTS DUE TO MEDICARE OR PROVIDERS BY COST REPORT CATEGORY**

**Table 1: Total Cost Reports and Amounts Due**

<b>Grand Total</b>	<b>Due to Medicare</b>	<b>Due to Provider</b>
<b>23 Cost Reports</b>	<b>\$17,585,811</b>	<b>\$3,171,762</b>

**Table 2: Cost Reports Not Referred (OIG Identified)**

Cost Report Category	Reconciled	Not Reconciled				Total
		Within 3 Years		Past 3 Years	Not Reconciled Subtotal	
		In Process	On Hold			
<b>Number of Cost Reports</b>	0	0	4	7	11	11
<b>Balance Due to Medicare</b>	\$0	\$0	\$2,648,863	\$4,701,587	\$7,350,450	\$7,350,450
<b>Interest Due to Medicare</b>	0	0	424,689	1,212,406	1,637,095	1,637,095
<b>Balance Due to Provider</b>	0	0	1,354,138	0	1,354,138	1,354,138
<b>Interest Due to Provider</b>	0	0	360,814	0	360,814	360,814
<b>Total Due to Medicare</b>	<b>\$0</b>	<b>\$0</b>	<b>\$3,073,552</b>	<b>\$5,913,993</b>	<b>\$8,987,545</b>	<b>\$8,987,545</b>
<b>Total Due to Provider</b>	<b>\$0</b>	<b>\$0</b>	<b>\$1,714,952</b>	<b>\$0</b>	<b>\$1,714,952</b>	<b>\$1,714,952</b>

**Note:** The dollar amounts associated with these cost reports do not reflect the two OIG-identified claims that we were unable to recalculate.

**Table 3: Cost Reports Referred (Medicare Contractor Identified)**

Cost Report Category	Reconciled	Not Reconciled			Total	
		Within 3 Years		Past 3 Years		Not Reconciled Subtotal
		In Process	On Hold			
<b>Number of Cost Reports</b>	0	7	3	2	12	
<b>Balance Due to Medicare</b>	\$0	\$4,427,481	\$3,416,762	\$0	\$7,844,243	
<b>Interest Due to Medicare</b>	0	353,052	400,971	0	754,023	
<b>Balance Due to Provider</b>	0	1,023,609	0	223,767	1,247,376	
<b>Interest Due to Provider</b>	0	141,541	0	67,893	209,434	
<b>Total Due to Medicare</b>	<b>\$0</b>	<b>\$4,780,533</b>	<b>\$3,817,733</b>	<b>\$0</b>	<b>\$8,598,266</b>	
<b>Total Due to Provider</b>	<b>\$0</b>	<b>\$1,165,150</b>	<b>\$0</b>	<b>\$291,660</b>	<b>\$1,456,810</b>	

**Note:** The dollar amounts associated with these cost reports do not reflect the three Medicare contractor-identified claims that we were unable to recalculate.

## APPENDIX C: AUDITEE COMMENTS



**Sandy Coston**  
CEO  
Novitas Solutions, Inc.  
Sandy.Coston@dsocorp.com

May 13, 2014

Mr. Patrick Cogley  
Regional Inspector General of Audit Services  
Office of Inspector General  
Office of Audit Services, Region VII  
601 East 12th Street, Room 0429  
Kansas City, MO 64106

RE: **A-07-11-02773**, Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required

Dear Mr. Cogley:

Novitas Solutions, Inc. (Novitas) has received the U.S. Department of Health & Human Services, Office of Inspector General (OIG) draft report entitled, "*Pinnacle Business Solutions Did Not Always Refer Medicare Cost Reports and Reconcile Outlier Payments as Required*" and reviewed the findings and recommendations. Novitas appreciates the opportunity to review and provide comments prior to the release of the final report.

In the draft report, the OIG outlined eight recommendations that Novitas has addressed as follows. Novitas has referenced each of these recommendations and numbered them accordingly. While these issues occurred under Pinnacle Business Solutions, Novitas acknowledges full responsibility to resolve them, as outlined below.

**Recommendation #1:** ". . . review the four cost reports that had not been settled and should have been referred to CMS for reconciliation but were not, take appropriate actions to refer these cost reports, and request CMS approval to recoup \$3,073,552 in funds and associated interest from health care providers (two cost reports) and refund that amount to the Federal Government and return \$1,714,952 in funds and associated interest from Medicare to providers (two cost reports)."

**Response #1:** Novitas Concurs – Novitas will request approval for outlier reconciliation from CMS. Once approval from CMS is received, the process to complete reconciliations will be completed.

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532 Riverside Avenue, Jacksonville, Florida 32202  
Tel: 904-791-8409  
Fax: 904-361-0372

**Recommendation #2:** “. . . review the seven cost reports that had been settled, had exceeded the three-year reopening limit, and should have been referred to CMS for reconciliation but were not, determine whether these cost reports can be reopened, and work with CMS to resolve \$5,913,993 in funds and associated interest from health care providers that may be due to the Federal Government.”

**Response #2:** Novitas Concurs - Novitas has reviewed these cost reports and determined that five of them have exceeded the three-year time limit per PRM-1-§-2931.1.A., and therefore, they cannot be reopened. CMS verbally confirmed this understanding, and Novitas will solicit CMS' written affirmation. For the remaining two cost reports, Novitas will complete appropriate corrective actions.

**Recommendation #3:** “. . . review the 10 cost reports that were referred to CMS and had outlier payments that qualified for reconciliation and work with CMS to:

- o reconcile the \$8,598,266 in associated outlier payments due to the Federal Government (eight cost reports), finalize these cost reports, and ensure that the providers return the funds to Medicare and
- o reconcile the \$1,165,150 in associated outlier payments due from Medicare to providers (two cost reports), finalize these cost reports, and return the funds to the providers.”

**Response #3:** Novitas Concurs - Novitas will review these cost reports, work with CMS, and complete appropriate corrective actions.

**Recommendation #4:** “. . . review the two cost reports that had exceeded the three-year reopening limit, were referred to CMS, and should have been reopened but were not, determine whether these cost reports can be reopened, and work with CMS to resolve the \$291,660 in funds and associated interest that may be due from Medicare to health care providers.”

**Response #4:** Novitas Concurs - Novitas has reviewed these cost reports and determined they have exceeded the three-year time limit, per PRM-1-§-2931.1.A., and therefore, they cannot be reopened. CMS verbally confirmed this understanding, and Novitas will solicit CMS' written affirmation.

**Recommendation #5:** “. . . work with CMS to resolve the \$184,616 in outlier payments associated with the five claims that we could not recalculate.”

**Response #5:** Novitas Concurs - Novitas will work with CMS and complete appropriate corrective actions.

**Recommendation #6:** “Ensure control procedures are in place so that all cost reports whose outlier payments qualify for reconciliation are correctly identified, referred, and, if necessary, are reopened before the three-year reopening limit.”

**Response #6:** Novitas Concurs - Novitas has revised the control procedures related to the Outlier Reconciliation process so that all cost reports whose outlier payments qualify for reconciliation are correctly identified, referred, and if necessary, are reopened before the three-year reopening limit.

Mr. Patrick Cogley, Regional Inspector General for Audit Services  
May 13, 2014  
Page 3

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**Recommendation #7:** “Ensure policies and procedures are in place so that it reconciles all Outlier payments with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines.”

**Response #7:** Novitas Concurs - Novitas has revised policies and procedures related to the Outlier Reconciliation process so that Novitas reconciles all outlier payments with all referred cost reports that qualify for reconciliation in accordance with Federal guidelines.

**Recommendation #8:** “Review all cost reports submitted since the end of our audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.”

**Response #8:** Novitas Concurs - Novitas will review these cost reports submitted since the end of the audit period and ensure that those whose outlier payments qualified for reconciliation are referred and reconciled in accordance with Federal guidelines.

Again, we appreciate the opportunity to review and provide comments prior to release of the final report. If you have any questions regarding our responses, please contact Mr. Gregory W. England at (904) 791-8364.

Sincerely,



Sandy Coston

cc: Gregory W. England