Implementation of Recovery Auditing at the Centers for Medicare & Medicaid Services

FY 2010 Report to Congress
As required by Section 6411 of Affordable Care Act

Centers for Medicare & Medicaid Services

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Executive Summary

Background

The Medicare Fee-for-Service (FFS) program consists of a number of payment systems, with a network of contractors that process more than 1 billion claims each year, submitted by more than 1 million providers, such as hospitals, physicians, skilled nursing facilities (SNF), labs, ambulance companies, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. These Medicare contractors, called "claims processing contractors," process claims, make payments to health care providers in accordance with Medicare regulations, and educate providers regarding how to submit accurately coded claims that meet Medicare guidelines. Despite actions to prevent improper payments, through such efforts as prepayment system edits and limited medical record reviews, it is impossible to prevent all improper payments due to the large volume of claims.

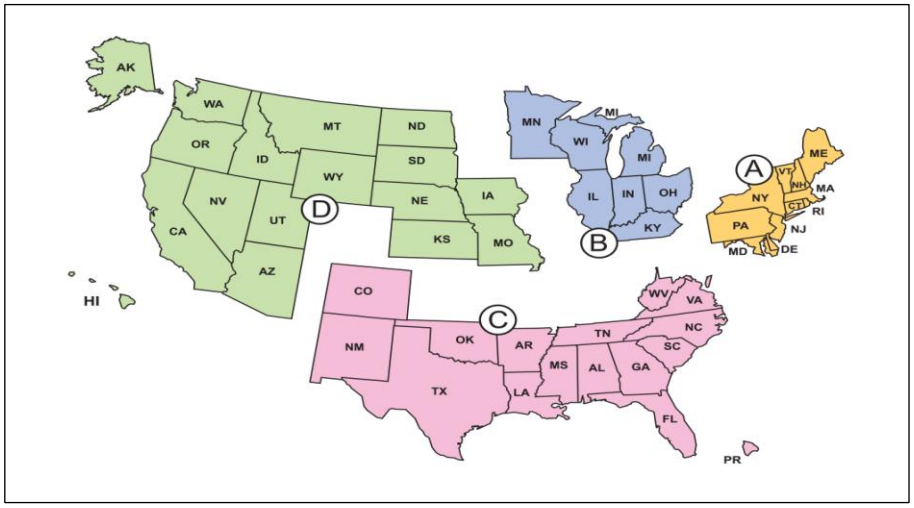
There are multiple circumstances that can result in improper payments, including payment for items or services that do not meet Medicare's coverage and medical necessity criteria, payment for items that are incorrectly coded, and payment for services where the supporting documentation submitted did not support the ordered service.

The Recovery Audit Program

In accordance with Section 306 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), a Recovery Audit demonstration was conducted from March 2005 to March 2008, in six states, to determine if Recovery Auditors could effectively be used to identify improper payments for claims paid under Medicare Part A and Part B. The RAC demonstration was an important tool in helping CMS prepare for and shape the RAC permanent program. This preparation led to the incorporation of several important components of the RAC permanent program, including building cooperative relationships with Medicare claims processing contractors, fraud fighters, the Department of Justice, and appeals entities; contracting with a RAC validation contractor to conduct independent third-party reviews of RAC claim determinations; limiting the claim review look-back period to three years; requiring each RAC to hire a medical director; and conducting significant outreach to providers. Due to the success of the Recovery Audit demonstration, the U.S Congress passed the Tax Relief and Health Care Act of 2006, which authorized the expansion of the Recovery Audit program nationwide by January 2010.

To implement the National Recovery Audit program, the Centers for Medicare & Medicaid Services (CMS) divided the country into four regional areas. Below is a map that shows the four regional areas.

Recovery Audit Regions



A full and open competition was held in the spring of 2007 to procure four Recovery Auditors for the nationwide program. The selected national Recovery Auditors were announced on October 6, 2008. However, due to two filed protests by unsuccessful bidders, implementation of the program was halted in late October. Both protests were withdrawn on February 4, 2009 allowing program implementation to resume.

Each Recovery Auditor is responsible for identifying improper payments in one of four regions. As with any large scale initiative, CMS expected the nationwide Recovery Audit program to have a 9–12 month implementation period. It was extremely important that CMS ensure the program operated efficiently and effectively; and that there was no undue burden to providers before significant reviews were performed by the Recovery Auditors. Based on lessons learned from the demonstration and commitments made to the various provider communities, CMS conducted extensive implementation efforts across the country, including provider outreach in all 50 states, data analysis reviews to ensure the quality of the Recovery Auditors' decisions, coordination between the Recovery Auditors and their respective claims processing contractor, established a New Issue Review Board comprised of CMS Medicare policy experts who pre-approve all new issues before widespread review, and reviewed and refined other operational efforts.

In addition, the Recovery Audit Contractor Data Warehouse—developed during the demonstration program to automate administration and oversight of the program—was overhauled to provide improved data collection and analysis about the Recovery Audit program. The Data Warehouse is an important tool for measuring the performance of the Recovery Auditors, as well as an important source of data for providers to understand program vulnerabilities and areas for their compliance officers to review and focus on.

Implementation of Recovery Auditors in Medicare Advantage, Medicare Prescription Drug and Medicaid Programs

Section 6411(b) of the Affordable Care Act (ACA) expanded the use of recovery audit contractors (RAC) to all of Medicare, amending the existing RAC statutory requirement for Medicare Part A and Part B at section 1893(h) of the Social Security Act. CMS has initiated implementation of Part C and Part D RACs. A contract for Part D recovery auditing was awarded on January 13, 2011. In addition to the Part D RAC procurement activity, CMS solicited comments on how best to implement the Medicare Part C and Part D recovery auditing program through a Request for Information (RFI) that was published in the Federal Register on December 27, 2010. Analysis of the comments received will assist CMS with implementation of a Part C RAC and the remaining statutory requirements under Section 6411(b).

FY 2010 FFS Recovery Audit Program Results

FY 2010 was the first year in which the Recovery Auditors began actively identifying and correcting improper payments under the National Recovery Audit program. All the Recovery Auditors began reviewing claims in October 2009. In the past fiscal year, the Recovery Auditors identified and corrected $92.3 million in combined overpayments and underpayments. Eighty-two percent of all Recovery Audit program corrections were collected overpayments, and 18 percent were identified underpayments that were refunded to providers.

The Recovery Auditors' identify these over and underpayments by reviewing the supporting medical records or through automated analysis of certain claims. The breakdown of total corrections in FY 2010 by each Recovery Auditor is reflected in the chart below.

Region	Recovery Auditors	Amount Corrected (Millions)
Region A	Diversified Collection Services (DCS)	$ 5.9
Region B	CGI, Inc.	15.5
Region C	Connolly, Inc.	27.5
Region D	HealthData Insights (HDI)	43.4
	Total:	**$92.3**

Much of FY 2010 was spent refining processes, improving operations and gaining experience with the various partners including the claims processing contractors and the provider communities. The Recovery Auditors who participated in the demonstration were able to leverage their prior experience to shorten their learning curve. HDI and Connolly's prior experience identifying Medicare improper payments is evidenced in their overall correction results for FY 2010.

The FY 2010 Findings section of the report contains detailed analysis of the Recovery Audit program, including collection and underpayment data by claim types. The appendices also contain additional information about the National program.

Introduction

Background

Faced with increasing national health expenditures and a growing beneficiary population, the importance and challenge of safeguarding the Medicare program are greater than ever. The Centers for Medicare & Medicaid Services (CMS) has a long history of developing strategies to protect the program's fiscal integrity that include -- calculation of an error rate for improper payments made to providers, development of robust corrective actions to reduce and prevent those improper payments from occurring in the future, and targeting remediation programs to educate and assist health care providers in the claims submission process.

Every fiscal year each Medicare Administrative Contractor (MAC) is required to complete an Error Rate Reduction Plan (ERRP) which includes agency-level strategies to clarify CMS policies and implement new initiatives to reduce improper payments. The ERRPs may include pilot studies to determine the impact of errors and the feasibility of an edit preventing future improper payments, general and provider specific education initiatives and more prepayment review on particular claim types.CMS actions to safeguard Federal funds are not merely limited to the claims processing actions and error rate programs. CMS also uses Zone Program Integrity Contractors (ZPICs) to identify potential problem areas, investigate potential fraud, and develop fraud cases for referral to law enforcement and coordinate Medicare fraud, waste and abuse efforts with CMS internal and external partners. The Recovery Audit program is another valuable tool to assist CMS in the identification and recovery of improper payments. All of these activities support CMS' efforts to prevent improper payments from occurring in the first place.

Recovery Audit Program Legislative History

In the Medicare Prescription Drug, Improvement and Modernization Act of 2003, Congress authorized CMS to complete a demonstration program to determine whether Recovery Auditors could efficiently and effectively identify Medicare overpayments or underpayments and recoup the overpayments. The demonstration program provided evidence that the Recovery Audit program was a useful and cost-effective tool for identifying and recovering improper payments.

Prior to the completion of the Recovery Audit demonstration program, Congress authorized the expansion of the Recovery Audit program nationwide by January 2010 in the Tax Relief and Health Care Act of 2006 (Appendix A). The CMS devoted the first 9–12 months of the National Recovery Audit program to implementation activities, and in August 2009, the program began limited operations to review Medicare payments.

Annual Report to Congress

This annual report focuses on activities of the Recovery Audit program, CMS' national program to identify and correct Medicare payment errors through post-payment review, for the fiscal year (FY) 2010, (specifically October 1, 2009–September 30, 2010).

This report is the first annual report for the national Recovery Audit program. The last report issued in 2008 contained information about the results and an evaluation of the three-year demonstration. This report summarizes and presents data on improper payments identified and corrected through the end of FY 2010. It also discusses the large number of CMS initiated or executed systemic improvements, CMS identified during the demonstration, to the national program.

This report satisfies the requirement in the Tax Relief and Healthcare Act of 2006 (Public Law 109-432) requiring an annual Report to Congress including information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this title. This report also satisfies the requirement in The Patient Protection and Affordable Care Act (Public Law 111-148) which requires an annual report to Congress concerning the effectiveness of the Recovery Audit Program under Medicaid and Medicare as well as recommendations for expanding or improving the program.

Medicare FFS Claims Processing

The Medicare Fee-for-Service (FFS) program processes over 1 billon claims annually, which are submitted by over 1 million providers. Providers include hospitals, skilled nursing facilities (SNF), physicians, laboratories, ambulance services, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. The claims are paid by a network of claims processing contractors who make payments to the providers in accordance with Medicare rules and regulations; perform pre-payment review of selected claims; and educate providers about how to submit accurately coded claims that meet Medicare medical necessity guidelines. While all claims submitted to Medicare are screened by thousands of system edits prior to payment, claims are generally paid without requesting the supporting medical records. Approximately 0.002 percent of claims are reviewed against the supporting medical records prior to payment. As a result, improper payments are sometimes made to providers and suppliers by Medicare. Due to the volume of claims received and limited resources CMS must rely on the post-payment review of claims to identify erroneous payments. Since the Recovery Auditors are paid a percentage of the dollars they correct, their activities are self-funded unlike traditional claims processing activities.

Improper Payments in the Medicare FFS program

Improper payments on claims fall into three categories:

- Payment for items or services that do not meet Medicare's coverage and medical necessity criteria.
- Payment for items that are incorrectly coded.
- Payment for services where the supporting documentation submitted does not support the ordered service.

Improper payments can be either an overpayment when the provider owes Medicare or an underpayment where Medicare owes the provider. Overpayments result in amounts collected from a provider and underpayments result in payment to a provider. In rare situations, improper payments can be identified because a provider failed to submit documentation when requested.

Medicare FFS Recovery Audit Program Contract Awardees

As a result of the success of the demonstration program, in spring 2007 CMS began the process of procuring, and ultimately acquiring, four Recovery Auditors through a full and open competition. In October 2008, CMS announced the award of the four new permanent Recovery Auditor contracts. The new Recovery Auditors and their corresponding regions are:

- Diversified Collection Services, Inc. (DCS) of Livermore, California (Region A).
- CGI Federal (CGI) of Fairfax, Virginia (Region B).
- Connolly, Inc. (Connolly) of Wilton, Connecticut (Region C).
- HealthDataInsights, Inc. (HDI) of Las Vegas, Nevada (Region D).

Due to protests of the Recovery Auditor awards by two unsuccessful bidders, CMS was required to impose an automatic stay on the contract work of the four newly awarded Recovery Auditors. In February 2009, the protests were withdrawn, and the national Recovery Audit program began implementation activities.

Each Recovery Auditor is responsible for identifying overpayments and underpayments in a geographically defined area that is roughly one-quarter of the country. In addition, the Recovery Auditors are responsible for highlighting to CMS common billing errors, trends, and other Medicare payment issues. The Recovery Auditors are paid on a contingency fee basis for both overpayments and underpayments that are identified and corrected. The regional distribution of the Recovery Audit program is as follows:

Region A: Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, and Washington, DC.

Region B: Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.

Region C: Alabama, Arkansas, Colorado, Florida, Georgia, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, Puerto Rico, South Carolina, Tennessee, Texas, U.S. Virgin Islands, Virginia, and West Virginia.

Region D: Alaska, American Samoa, Arizona, California, Guam, Hawaii, Idaho, Iowa, Kansas, Missouri, Montana, Nebraska, Nevada, North Dakota, Northern Mariana Islands, Oregon, South Dakota, Utah, Washington, and Wyoming.

Implementation of the FFS National Recovery Audit Program

As expected, the initial implementation and outreach phases of the Recovery Audit program took 9–12 months, which amounted to most of calendar year 2009. During this phase, CMS required the Recovery Auditors to meet administrative requirements and set up technical, reporting, and workflow capabilities to cover 56 States and territories prior to the start of the program. Specifically, Recovery Auditors were tasked with requirements such as receiving data from CMS, analyzing the data, establishing communications and setting up Joint Operating Agreements with approximately 25 claim processing contractors, and submitting review issues to CMS for approval.

Provider Outreach

The CMS also worked to prepare and educate the provider community about the program by performing 179 outreach sessions between February and September of 2009. CMS and the Recovery Auditors also reached out to major medical, provider, and hospital associations in each State to conduct face-to-face outreach sessions. Additionally, multiple open-door forums, conference calls, and "Webinars" were held for providers throughout the country. By October 2009, CMS had conducted outreach sessions in every state. CMS also availed information through public media and other sources of communication, including enhancements to the CMS Recovery Audit webpage, posting an educational video clip on the "YouTube" website, establishing a specific Recovery Audit e-mail address and development of a frequently asked questions document to address provider concerns.

Contract Administration and Data Transmission

On May 14, 2009, the Recovery Auditors completed a data transmission from CMS for claims paid from October 1, 2007, to March 31, 2009, for Regions A, C, and D. Transmissions for Region B were completed on July 15, 2009. The Recovery Auditors continue to receive updated data files on a monthly basis.

During the implementation period, it was extremely important that CMS institute strong internal processes to ensure the program operated efficiently and effectively; that provider burden was minimized; that the auditors' decisions were accurate; that the program was transparent; and that there was a strong provider education element. In Fiscal Years 2009 and 2010, CMS held five kick-off or operational meetings. These meetings provided an opportunity for all Recovery Auditors to have an in-person discussion with CMS regarding questions and/or concerns; to collaborate with other Recovery Auditors on successes, or issues, related to their operations; and to receive continuing education from CMS about current issues and expectations. CMS also created an internal New Issue Review Board, comprised of CMS policy experts and experienced clinicians, to discuss the relevancy and meaningfulness of potential audits. In addition, CMS hired an independent contractor, known as the Recovery Audit Validation Contractor. The Recovery Audit Validation Contractor reviews potential audit areas and makes suggestions for the approval or rejection of proposed audits. This contractor also reviews the Recovery Auditors' processes and decision making, as well as, assessing demand letters for clarity, accuracy, and completeness.

Although CMS met program implementation goals, we continue to strive toward increased claim adjustments by creating more efficient Recovery Audit processes. The CMS continues to work closely

with its contractors during these initial stages of claim review, so that audits are based on reliable, CMS-supported measures of evaluation that are not overly burdensome to Medicare providers.

System Improvements

Specifically, the CMS and its contractors honed in on the efficacy of the implemented technological processes. Recovery Auditors continued to modify their utilization of the secure data exchanges, known as MDCN lines, which once fully established and open offer secure connectivity between CMS, Recovery Auditors, the claims processing contractors, and other requisite sources (i.e. Office of Inspector General, Qualified Independent Contractors) for data transmission.

The CMS also implemented a mass adjustment system, which allowed the claims processing contractors to adjust claims on a mass file basis. This change mandates the creation of reports to monitor Recovery Auditor initiated collections and/or underpayments returned to Providers. These tasks required significant collaboration between CMS; the three standard systems maintainers, Recovery Auditors and claims processing contactors and took approximately two years to fully implement. The wholly functional mass adjustment system has allowed for timelier claim adjustments, and is a process which CMS continues to monitor and enhance.

Another management tool that CMS created specifically for this program is the Recovery Audit Data Warehouse. This tool allows CMS to generate reports which indicate the types of claims auditors are focusing their reviews on and the claims that are resulting in the most corrections; these reports are available from identification through recoupment. Future enhancements to the system will include information about appeal results. The Data Warehouse is a restricted-access system, which serves as the repository for data about all claims reviewed by the Recovery Auditors. The Data Warehouse is the principal data source for reporting corrected claim results to CMS. The Data Warehouse is used by CMS to ensure that Recovery Auditors do not review claims previously subjected to medical record review by another review entity, such as a claims processing contractor, or that are currently under review by law enforcement. Several entities involved with the Recovery Audit program rely on the Data Warehouse to perform essential functions, including CMS, Recovery Auditors, Program Safeguard Contractors (PSCs), Zone Program Integrity Contractors (ZPICs), and law enforcement agencies.

The CMS has also invested time and resources into the development and implementation of a system to allow the sharing of medical records and other supporting documentation with various Medicare contractors electronically. This system is still in its infancy but once fully implemented will allow the electronic submission of medical records between providers, the Recovery Auditors and CMS. This system will also facilitate the approval of new issues and the review of cases to ascertain the accuracy of the Recovery Auditors' decisions. Future system enhancements will allow the sharing of supporting documentation electronically for appeal purposes and the storage of correspondence.

Review Strategy

Finally, CMS implemented a "review strategy" to gradually expand claim types available for Recovery Auditor review to ensure Recovery Auditor comprehension of CMS policies and to allow the provider community the opportunity to prepare for the Recovery Audit program. The review strategy began with automated reviews which typically focused on DME, physician and outpatient claims. These reviews began in late FY 2009. In late FY 2009 and early FY 2010 CMS expanded the Recovery Auditors' scope of review to complex coding issues and Diagnosis Related Group (DRG) validations. Finally, in late FY 2010 CMS expanded the scope of the review strategy to include medical necessity reviews.

The aforementioned implementation efforts proved to be labor and time intensive for both CMS and the Recovery Auditors, but the efforts and modifications provided a solid foundation for a successful, long-term Recovery Audit program.

Status of the Recovery Audit Program for Medicare Advantage, Medicare Prescription Drug, and Medicaid Programs

Although this report focuses on the implementation and results of the national Recovery Audit program for the Medicare Fee-for-Service (FFS) program, we wanted to note that CMS was recently granted authority from the Affordable Care Act to use Recovery Auditing in the Medicare Advantage (Part C), Medicare Prescription Drug (Part D), and Medicaid programs. Below is information about the authority and status of these efforts.

Medicare Parts C and D

Section 6411(b) of the Affordable Care Act (ACA) expands the use of recovery audit contractors (RACs) to all of Medicare, amending the existing RAC statutory requirement for Medicare Part A and Part B at section 1893(h) of the Social Security Act.

The ACA amendments to 1893(h) provide CMS with authority to enter into contracts with RACs to identify overpayments and underpayments and recoup overpayments in Parts C and D. Section 6411(b) also sets forth "special rules" for RACs when looking for Part C and D overpayments. Under the special rules in Section 6411(b) RACs must: ensure that each Medicare Advantage (MA) plan under Part C has an anti-fraud plan in effect and review the effectiveness of each such anti-fraud plan; ensure that each prescription drug plan under Part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan; examine claims for reinsurance payments under section 1860D-15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans. The ACA required that contracts providing for national coverage be in place by December 31, 2010.

CMS has taken several steps towards implementation of Part C and Part D RACs. On January 13, 2011, CMS awarded a contract for Medicare Part D recovery auditing to ACLR Strategic Business Solutions. Under this contract, ACLR Business Solutions will identify under and overpayments and recoup overpayments in the Medicare Part D program. A date certain for initiation of recovery audits has not yet been established. Prior to launching the recovery audit program, the RAC will be fulfilling CMS systems access requirements; developing outreach plans to Part D sponsors; and working with CMS to establish priorities for recovery auditing.

In addition to the Part D RAC procurement activity, a Request for Information (RFI) was published in the Federal Register on December 27, 2010. In this RFI, CMS solicited comments on how best to implement the Medicare Part C and Part D RAC to accommodate complexities inherent in the Medicare Part C and D payment methodologies as well as complexities associated with the contractual relationships between Plan Sponsors and CMS. The comment period closed for the request for information on February 25, 2011. Analysis of these comments will assist CMS with implementation of a Part C RAC and the remaining statutory requirements under Section 6411(b).

Medicaid

Section 6411(a) of The Affordable Care Act amended section 1902(a) (42) of the Social Security Act to require that States and territories establish Medicaid Recovery Audit Contractor (RAC) programs by December 31, 2010. States are required by statute to contract with one or more RACs to identify overpayments and underpayments and to recover overpayments from Medicaid providers. States are expected to administer their Medicaid RAC programs within the federal regulatory framework.

On October 1, 2010, CMS issued a State Medicaid Director Letter to provide initial guidance on the implementation of these RAC programs. Each State and territory was required to submit a State Plan amendment (SPA) to CMS, in order to establish a State Medicaid RAC program subject to the exceptions and requirements provided by the Secretary. As of May 2011 CMS granted a total of 14 exception requests from States and territories. The two largest sub-categories of exceptions were requests from States for delay of implementation and complete exemption from implementing a RAC program on the basis of Medicaid claims system infrastructure challenges.[1]

During the fall of 2010, CMS hosted several activities for States to provide technical assistance in the establishment of their Medicaid RAC programs. These activities included a webinar on procurements tips, two All-State calls on program guidance and lessons learned from the Medicare RAC program and the distribution of an informational video on elements to consider when designing a Medicaid RAC program. A Notice of Proposed Rule Making was published on November 10, 2010. The comment period closed on January 10, 2011, and we anticipate issuing the final rule later this year. The originally proposed implementation date of April 1, 2011, was delayed in order to allow States sufficient time to develop their RAC programs. States are now in the process of implementing their Medicaid RAC programs, and CMS continues to provide support to the States during this process.

On February 17, 2011, CMS launched its Medicaid RACs At-A-Glance website which serves as a basic information source on the Medicaid RAC programs. The site reflects basic information about the status of each State's RAC program and details related to the exception requests that were submitted. In the future, CMS plans to enhance this site with information on Medicaid RAC program performance. CMS will be working with the States to establish performance measures for Medicaid RAC programs. The website can be found at http://www.cms.gov/medicaidracs/.

Section 6411 of the Affordable Care Act requires the Secretary to report annually on the Medicare and Medicaid RAC programs. While the 2010 Report to Congress focuses on Medicare fee-for-service RACs, subsequent reports will contain greater detail on the status, implementation, and outcomes of the Medicare Parts C and D and Medicaid RACs.

[1] [1] CMS has granted exceptions to each of the five U.S. Territories allowing a complete exemption from implementing a RAC program.

FFS Recovery Audit Review Process

In FY 2010, the Recovery Audit program included only the Medicare Fee-for-Service (FFS) Recovery Audits. It did not include the identification and recoupment of improper payments for Medicare Advantage (Part C), Medicare Prescription Drug (Part D), and Medicaid; however CMS is in the process of designing the Recovery Audit programs for these three areas.

Currently, Recovery Auditors review FFS claims on a post-payment basis. CMS has limited the look-back period for Recovery Auditor reviews to a maximum of 3 years, with claims paid prior to October 1, 2007 ineligible for review. Recovery Auditors follow the same claims review policies and procedures that apply to other Medicare contractors. The Recovery Auditors employ their own internal methods and tools to identify potential claims for review: Recovery Auditors do not develop or apply their own coverage, coding, or billing policies. Recovery Auditors follow two review processes, also used by the claims processing contractors, to identify improper payments: automated review and complex review.

Improper Payment Identifcitation

To identify and correct improper payments, the following process occurs:

Review

Automated review:

- This is an automated review of claims using analytics to identify improper payments.

Complex review:

- This requires a review of the supporting medical records to determine whether there is an improper payment.

Demand

After the claims processing contractor notifies the provider of the improper payment, the next step in the process is notification of the overpayment. The Recovery Auditor notifies the provider in the form of a "demand" letter that there has been an improper payment, with accompanying rationale for the determination. The demand letter is an essential source of information regarding the rationale for a claim adjustment and instructs providers on how to proceed for additional adjudication or appeal.

Overpayment:

- In the case of an overpayment, the letter requests repayment of the specific amount adjusted. This collections process is the same for claims reviewed using either the automated or complex review process.

Underpayment:

- In the case of an underpayment, the letter notifies the provider of the underpayment and the repayment process.

Appeals Process

The appeals process is a multilevel approach that allows providers to appeal a Recovery Auditor's overpayment determination. This process is exactly the same for all providers who want to appeal a Medicare claim decision. The levels of appeal are described below.

1. Redetermination is performed by the claims processing contractor.
2. Reconsideration is performed by the Qualified Independent Contractor (QIC).
3. Administrative Law Judge (ALJ) Hearing
4. Appeals Council Review
5. Final Judicial Review (Federal District Court Review)

Collection and Repayment

Collection efforts for overpayments and repayments of underpayments are handled by the provider's claims processing contractor. The recoupment of an overpayment may be offset against future payments made by the claims processing contractor if payment is not received by a specific time period. The provider may also apply for an extended repayment plan. Typically, recoupment from future repayments cannot occur until 41 days after the adjustment/date of demand letter. In addition, the receipt of a valid appeal may also delay recoupment. Underpayments are paid back to the provider by the claims processing contractor.

How Recovery Auditors are Paid

Recovery Auditors are paid based on a contingency fee basis. The amount of the contingency fee is based on the amount of money recovered from, or reimbursed to, providers. The contingency fee is a percentage of the amount of the improper payment. In FY 2009 and FY 2010 the contingency fees ranged from 9.0%-12.5%. The fee is paid once the money is recouped or refunded, not when the improper payment is first identified. The Recovery Auditor must return the fee if an overpayment/underpayment is overturned at any level of appeal.

Key Program Components

Having successfully completed the implementation phase, the Recovery Auditors shifted attention to their main task of identifying and correcting improper payments. During the Recovery Audit demonstration program, CMS identified five key success factors for measuring the success of the Recovery Audit program; minimizing provider burden, ensuring accuracy, maximizing transparency, ensuring the program operated efficiently and effectively, and a robust provider education function. CMS used these factors to design and implement the national program and continues to use these factors to improve the Medicare FFS program.

Ensuring Accuracy

To ensure claims are accurately reviewed, each Recovery Auditor is required to employ certified coders, nurses, and/or therapists. On a case-by-case basis, Recovery Auditors often consult with physician specialists for complex matters involving medical necessity determinations.

Following the demonstration, CMS also mandated that each Recovery Auditor employ a physician Medical Director. The Medical Director oversees the medical record review process; assists nurses, therapists, and certified coders during complex review; manages the quality assurance procedures; conducts discussions with providers when requested; and informs provider associations about the Recovery Audit program. The addition of the Medical Director position provides another layer of protection in potentially avoiding wrongful determinations.

As discussed briefly in the preceding section, when a Recovery Auditor identifies a new issue with regard to improper payment determinations, CMS reviews the new issue and determines if the issue is appropriate for review. All new issues are reviewed by a panel of CMS experts, who ensure that the claims are properly reviewed against CMS' policies. Once an issue is approved, it must be posted to the Recovery Auditor's website for public notification before widespread reviews can take place. The Recovery Audit Validation Contractor also provides external validation and helps ensure the accuracy of the Recovery Auditor claim determinations by conducting independent, third-party reviews of improper payments identified by the Recovery Auditors. The Recovery Audit Validation Contractor reviews a sample of claims for accuracy and provides feedback for each Recovery Auditor about areas where improvement is needed.

As previously mentioned, if an improper payment determination is overturned at any level of appeal, the Recovery Auditor contingency fee must be returned to CMS. This process helps ensure the accuracy of the Recovery Auditors' reviews.

Ensuring the Program Operates Efficiently and Effectively

The CMS continues to improve the processes utilized by the Recovery Audit program to ensure it operates efficiently and effectively for all stakeholders. This includes lowering the cost to complete the administration of the program and minimizing the impact on providers. Many steps were taken in FY 2010 to continue to effectively administer the program. The CMS completed system modifications to allow the adjustment of a large number of claims at one time forgoing manual claim adjustments, streamlined the new issue approval process allowing for quicker decisions regarding what can be reviewed and continued to foster the professional relationships between the Recovery Auditors and claim processing contractors to allow for more collaboration and sharing of potential review areas. Additional

steps were taken to minimize the impact of the Recovery Audit program on providers. For example, CMS enhanced the understanding of the discussion period following the completion of the audit to allow for discussions on the improper payment determination between the provider and the Recovery Auditor Medical Director. The CMS continues to work with the Recovery Auditors so that they provide adequate information regarding the reasons for the denial on all demand letters.

Maximizing Transparency

CMS requires that issues be posted on the Recovery Auditors' websites, which improves transparency to the public and the provider community. As discussed earlier, Recovery Auditors post online CMS-approved issues that may trigger a Recovery Auditor review. CMS recently began posting additional information to our website related to Recovery Auditor recoveries on a quarterly basis.

Recovery Auditors are required to give the provider a detailed rationale of the improper payment determination. Following any complex review, Recovery Auditors are required to issue a detailed "review results" letter to the provider outlining any improper payments identified, along with references supporting the determination. This letter does not constitute a demand for repayment; it serves to notify the provider of a potential over/underpayment and explain the determination. It may also be used as notification of "no findings" for improper payment during the review. For automated reviews, the detailed rationale or explanation of the improper payment determination is included in the demand letter.

This letter is crucial to the program's goal of improper payment and error reduction. In order for providers to comprehend the outcome of the audit, and subsequent required corrections, they must first understand the policy and/or medical basis supporting the decision. Therefore, reviewers include an excerpt for provider review including their understanding of the case (synopsis), the relevant policy for review, and why their claim met or failed the Medicare criteria.

Minimizing Provider Burden

CMS continues to work with the provider community to reduce the burden of the review process. In doing so, CMS has limited the look-back period for Recovery Auditor reviews to a maximum of 3 years, or claims paid after October 1, 2007. This is consistent with CMS' claims re-opening and liability policies. In addition, Recovery Auditors are required to accept imaged medical records on CD/DVD to reduce costs and labor associated with paper transmissions. Instructions for submission via CD/DVD can be found on each individual Recovery Auditor's website. Lastly, CMS has limited the number of additional documentation requests that a Recovery Auditor may request at one time, based on provider size and resources. The CMS continues to work with hospital and medical associations in order to receive and respond to provider concerns and further reduce provider burden.

Developing Robust Provider Education

The Recovery Audit program is a valuable tool for CMS in developing provider education and outreach to further support the agency's efforts to pay claims correctly. As potential vulnerabilities are reviewed and identified by the Recovery Auditors, CMS determines the appropriate steps necessary to prevent the improper payment from occurring. This may include system edits which prevent payment of a claim with certain characteristics, the publication of articles and bulletins on how to bill certain claim types, clarification of the CMS policy and the sharing of comparative billing data with providers. In addition to completing specific provider education, CMS shares the vulnerabilities identified in the Recovery Audit

program with the claims processing contractors so that they may use the information to improve their payment and review strategies as well as their educational strategies.

FY 2010 Results

Overview

FY 2010 was the first year in which the Recovery Auditors began actively identifying and correcting improper payments in the national Recovery Audit program. As mentioned previously, full scale recovery efforts for the national Recovery Audit Program began in July 2010. In FY 2010 the Recovery Auditors identified and corrected $92.3 million in both overpayments and underpayments. Seventy-five million dollars, or 82 percent of all Recovery Audit Program corrections, were collected overpayments. Eighteen percent, or $16.9 million, were identified underpayments that have been paid back to providers.

These correction figures illustrate what has already been collected or restored to providers in the past fiscal year. However, another important indicator of the Recovery Audit Program's success was the amount demanded in FY 2010. Demanded or identified improper amounts are those amounts identified by Recovery Auditors as improper overpayments or underpayments on claims submitted by health care providers, but not yet collected or restored. In FY 2010 the Recovery Auditors demanded $135.6 million in overpayments. Additional statistics can be found in Appendix B.

There are unavoidable systemic reasons for variations in the demanded amounts and collected amounts. The most prevalent reason for this occurrence relates to a CMS regulation granting providers a 41-day grace period prior to the initiation of collections. However, in some cases the lack of payment could relate to the expiration or financial decline of providers, or possibly their termination from the program. In addition, providers may be offered options for extended repayment, or CMS may withhold future earnings on unrelated claim submissions as an alternate means of collection.

Appeals

The CMS has received fairly successful feedback from an appeals perspective. To date, only 2.4 percent of all 2010 claims collected have been both challenged and overturned on appeal.[2] Interestingly, recent data also supports that the number of claims overturned on appeal may decrease in the future when CMS or the Recovery Auditor takes either participant or party status in a case; further supporting the accuracy of the Recovery Auditors' decisions.

Health care providers have appealed 8,449 claims to date, which constitutes 5 percent of all claims collected in FY 2010. Of those, 3,902 claims—2.4 percent of all collected claims—were ruled in the providers' favor, for a total overturned amount of $2.6 million. Monitoring appeals activity is a key part of the Recovery Audit program. CMS will continue to track the Recovery Auditor appeal rates.

Major Findings

The CMS tracks vulnerabilities, known as major findings, which are identified by the Recovery Audit program for the purposes of developing corrective actions. These major findings are tracked and corrective actions are monitored and adjusted as necessary. The CMS began posting top major findings on

[2] Health care providers have a generous amount of time to request an appeal at each of the four administrative appeal levels. Consequently the appeals process can take up to two years when the time for adjudicating the appeals is taken into account. Appeal data presented is for claims originating and appealed in FY2010. Future reports will begin with claims originating in FY 2010 and report any appeal actions occurring in that particular fiscal year.

the Recovery Audit website and produces quarterly newsletters to educate providers. This also allows providers to understand where improper payments are occurring so they can develop additional corrective actions. The Recovery Audit program has identified several program vulnerabilities and has worked to prevent them from occurring in the future. Samples of top identified issues resulting in identified overpayments are described below and in Appendix C and D.

	Overpayment Issues
Region A: Diversified Collection Services	**Ventilator Support of 96+ hours** – Ventilation hours begin with the intubation of the patient (or time of admittance if the patient is admitted while on mechanical ventilation) and continue until the endotracheal tube is removed, the patient is discharged/transferred, or the ventilation is discontinued after a weaning period. Providers are improperly adding the number of ventilator hours resulting in higher reimbursement. **(Incorrect Coding)**
Region B: CGI, Inc.	**Extensive Operating Room Procedure Unrelated to Principal Diagnosis**– The principal diagnosis and principal procedure codes for an inpatient claim should be related. Errors occur when providers bill an incorrect principal and/or secondary diagnosis that results in an incorrect Medicare Severity Diagnosis-Related Group assignment. (**Incorrect Coding)**
Region C: Connolly, Inc.	**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Provided During an Inpatient Stay**– Medicare does not make separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. Suppliers are inappropriately receiving separate DMEPOS payment when the beneficiary is in a covered inpatient stay. **(Billing for Bundled Services Separately)**
Region D: HealthDataInsights	**Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Provided During an Inpatient Stay**– Medicare does not make separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. Suppliers are inappropriately receiving separate DMEPOS payment when the beneficiary is in a covered inpatient stay. (**Billing for Bundled Services Separately)**

Corrective Actions

CMS has multiple processes in place for identifying and tracking Recovery Auditor issues that expose potential program vulnerabilities. When the Recovery Auditors upload claims information to the Data Warehouse, they report important review information, such as the number of claims with improper payments, a description of the issue, provider type, error type, and whether an improper payment was identified through automated or complex review. In addition, Recovery Auditors report to CMS the dollar amount collected or paid back, all appeals statistics, and the dollar amount in error less those appealed or adjusted. With every new review, the Recovery Auditors submit to CMS a short description of the improper payment, the codes affected, and a reference that describes why the issue resulted in an improper payment.

Development of corrective actions to prevent improper payments is a continually improving process at CMS and is an agency-wide collaborative effort. CMS involves its various components to implement corrective action items, which include: provider education, policy changes and system edits. Corrective actions are an important priority for CMS, and require extensive collaboration between multiple CMS components and the claims processing contractors.

CMS has made significant progress with implementing corrective actions and holds regular conference calls with the claim processing contractors to discuss Recovery Auditor identifications and possible actions. In the last 6 months of FY 2010, some of the DME claims processing contractors input local system edits into the system for five (5) issues identified by the Recovery Auditors and CMS authored three (3) national system changes to the claim processing systems. Once implemented, these system changes will stop improper payments from being paid. In addition, in late FY 2010 CMS released three (3) Medicare Learning Network articles to providers concerning improper payment areas from the Recovery Audit demonstration. These notifications provide additional education to the provider community about types of improper payments and how providers can prevent improper payments in the future. Many other corrective actions are underway and CMS is exploring many other tools and analytic techniques to assist in the prevention of improper payments.

Continuous Improvement

The CMS is committed to working with the Recovery Auditors, the provider community, and others to continuously improve the program and refine ongoing operations. The Recovery Audit Program is constantly improving, based on "lessons learned" and "best practices" that CMS receives from the Recovery Auditors, providers, associations, and claims processing contractors. This feedback and continuous improvement will help CMS be successful in "paying the claim right, the first time".

In FY 2010, CMS implemented a new mass adjustment process for improperly paid claims, continued to increase the additional documentation request limits, and implemented a new issue-approval process for all issues reviewed by the Recovery Auditors. CMS has also taken a proactive approach to educate the Recovery Auditors on Medicare payment policies, statutes, and regulations to ensure that the Recovery Auditors are not erroneously identifying improper payments.

The CMS' ability to correct improper payments was dramatically enhanced in FY 2010 through the introduction of a mass adjustment process in all of the claims processing systems. These extensive system changes allow CMS to automatically adjust a large number of claims that have been paid improperly. This allows some claims to be adjusted with little or no manual intervention. CMS plans to continue to enhance the mass adjustment process by automating it as much as possible, as well as allowing the process to be used for improper payments identified by any review entity.

The CMS is very cognizant of the impact that the Recovery Audit program has on the provider community. To ensure compliance with Medicare policies and minimize provider burden, the CMS instituted a process to approve review areas identified by the Recovery Auditors prior to initiation of widespread review. CMS is continually improving this process to provide access to review areas to the Recovery Auditors and more information to providers. Providers can use the new issue information which is posted to the Recovery Auditor websites to conduct their own internal reviews. Recently, the new issue process was streamlined to allow for quicker approval of issues. In addition, since the onset of the national Recovery Audit program, CMS instituted additional documentation request limits. CMS will continue to reevaluate and update the additional documentation request limits annually.

Appendices

A. Applicable Laws
- A1. Tax Relief and Health Care Act of 2006 (Section 302)
- A2. Affordable Care Act (Section 6411)

B. Breakdown of Improper Payments
- Table B1. Collections and Underpayments by State Provider Outreach
- Table B2. Corrections by Recovery Auditor
- Table B3. Corrections by Part A, B, and DME Claims
- Table B4. Corrections by Recovery Auditor and Part A, B, and DME Claims
- Figure B1. Collections by Claim Type
- Figure B2. Breakdown of DME Claims (Physician versus Supplier)
- Figure B3. Collections by Claim Type and Recovery Auditor

C. Top Issues
- Table C1: Top 5 Issue Codes by Recovery Auditor- Collections
- Table C2: Top 5 Issue Codes by Recovery Auditor- Underpayments

D. Error Codes
- Table D1. Top Error Codes for Collections by Recovery Auditor
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E. Appeals
- Table C1. Appeals by Type and Recovery Auditor

F. Accuracy Scores
- Table F1. Number of Accuracy Score Reports and Cumulative Accuracy Score by Recovery Auditor

Appendix A1:
Tax Relief and Health Care Act of 2006

Sec. 302. Extension and expansion of recovery audit contractor program under the Medicare Integrity Program.

(h) USE OF RECOVERY AUDIT CONTRACTORS.—
(1) IN GENERAL- Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this title with respect to all services for which payment is made under part A or B. Under the contracts--

(A) payment shall be made to such a contractor only from amounts recovered;
(B) from such amounts recovered, payment--
(i) shall be made on a contingent basis for collecting overpayments; and
(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and
(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

(2) DISPOSITION OF REMAINING RECOVERIES- The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) shall be applied to reduce expenditures under parts A and B.

(3) NATIONWIDE COVERAGE- The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010.

(4) AUDIT AND RECOVERY PERIODS- Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under part A or B--

(A) during such fiscal year; and
(B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

(5) WAIVER- The Secretary shall waive such provisions of this title as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).

(6) QUALIFICATIONS OF CONTRACTORS-

(A) IN GENERAL- The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this title or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

(B) INELIGIBILITY OF CERTAIN CONTRACTORS- The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1816, a carrier under section 1842, or a Medicare administrative contractor under section 1874A.

(C) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY- In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under title XIX, or under this title.

(7) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD- A recovery of an overpayment to an individual or entity by a recovery audit contractor under this subsection shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(8) ANNUAL REPORT- The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this title.

Appendix A2:
Affordable Care Act

SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.
(a) EXPANSION TO MEDICAID.—
(1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—

(A) by striking ‘‘that the records’’ and inserting ‘‘that—
‘(A) the records’’;

(B) by inserting ‘‘and’’ after the semicolon; and

(C) by adding at the end the following: ‘‘(B) not later than December 31, 2010, the State shall—

‘‘(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and
‘‘(ii) provide assurances satisfactory to the Secretary that—

‘‘(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

‘‘(II) from such amounts recovered, payment—

‘‘(aa) shall be made on a contingent basis for collecting overpayments; and

‘‘(bb) may be made in such amounts as the State may specify for identifying underpayments;

‘‘(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and ‘

‘(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

‘‘(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

‘‘(bb) that section 1903(d) shall apply to amounts recovered under the program; and

‘‘(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State Medicaid fraud control unit; and’’.

(2) COORDINATION; REGULATIONS.—

(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State’s Medicaid program prior to December 31, 2010.

(B) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.

(b) EXPANSION TO MEDICARE PARTS C AND D.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title'';

(2) in paragraph (2), by striking ''parts A and B'' and inserting ''this title'';

(3) in paragraph (3), by inserting ''(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)'' after ''2010'';

(4) in paragraph (4), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title''; and

(5) by adding at the end the following:

''(9) SPECIAL RULES RELATING TO PARTS C AND D.—The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—'

'(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(C) examine claims for reinsurance payments under section 1860D–15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

''(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.''.

(c) ANNUAL REPORT.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and shall include such reports recommendations for expanding or improving the program.

Appendix B: Breakdown of Improper Payments

Table B1. Collections and Underpayments by State

State	Region	Collected			Restored			Total Corrected	
		No. of Claims	Total ($)	Mean Claim Amount ($)	No. of Claims	Total ($)	Mean Claim Amount ($)	No. of Claims	Total ($ M)
Alabama	C	1,202	$1,941,564	$1,615	66	$136,802	$2,073	1,268	$2.08
Alaska	D	1,265	313,499	248	26	84,925	3,266	1,291	0.40
American Samoa	D	6	2,347	391	0	-	-	6	0.00
Arizona	D	10,009	3,354,202	335	624	2,331,634	3,737	10,633	5.69
Arkansas	C	171	76,520	447	6	27,618	4,603	177	0.10
California	D	31,590	7,656,620	242	283	968,918	3,424	31,873	8.63
Colorado	C	192	278,354	1,450	4	9,043	2,261	196	0.29
Connecticut	A	453	345,222	762	1	4,384	4,384	454	0.35
Delaware	A	135	78,236	580	15	47,801	3,187	150	0.13
District of Columbia	A	46	44,196	961	0	-	-	46	0.04
Florida	C	8,236	7,146,845	868	172	609,267	3,542	8,408	7.76
Georgia	C	3,589	1,704,760	475	236	413,995	1,754	3,825	2.12
Guam	D	25	2,995	120	0	-	-	25	0.00
Hawaii	D	639	91,855	144	0	-	-	639	0.09
Idaho	D	1,528	748,708	490	10	79,518	7,952	1,538	0.83
Illinois	B	2,404	2,272,388	945	12	31,223	2,602	2,416	2.30
Indiana	B	5,205	2,785,308	535	11	23,397	2,127	5,216	2.81
Iowa	D	4,864	967,177	199	535	1,208,174	2,258	5,399	2.18
Kansas	D	4,426	1,275,887	288	313	857,843	2,741	4,739	2.13
Kentucky	B	1,899	1,003,899	529	2	2,492	1,246	1,901	1.01
Louisiana	C	638	1,012,076	1,586	26	95,841	3,686	664	1.11
Maine	A	259	85,580	330	32	100,288	3,134	291	0.19
Maryland	A	682	88,339	130	0	-	-	682	0.09
Massachusetts	A	951	567,704	597	121	480,535	3,971	1,072	1.05
Michigan	B	4,806	2,819,812	587	7	5,668	810	4,813	2.83
Minnesota	B	373	2,215,861	5,941	2	7,785	3,893	375	2.22
Mississippi	C	513	113,335	221	22	86,378	3,926	535	0.20
Missouri	D	8,309	2,329,104	280	1,038	3,022,477	2,912	9,347	5.35
Montana	D	2,209	695,033	315	109	230,888	2,118	2,318	0.93
Nebraska	D	2,891	620,120	215	224	738,927	3,299	3,115	1.36
Nevada	D	1,990	460,897	232	90	500,424	5,560	2,080	0.96

Table B1. Collections and Underpayments by State									
State	**Region**	**Collected**			**Restored**			**Total Corrected**	
		No. of Claims	**Total ($)**	**Mean Claim Amount ($)**	**No. of Claims**	**Total ($)**	**Mean Claim Amount ($)**	**No. of Claims**	**Total ($ M)**
New Hampshire	A	251	73,690	294	15	41,568	2,771	266	0.12
New Jersey	A	2,006	1,438,590	717	16	46,810	2,926	2,022	1.49
New Mexico	C	108	492,194	4,557	7	35,409	5,058	115	0.53
New York	A	3,175	1,086,956	342	3	11,032	3,677	3,178	1.10
North Carolina	C	857	1,037,221	1,210	4	10,473	2,618	861	1.05
North Dakota	D	1,614	424,606	263	83	217,755	2,624	1,697	0.64
Ohio	B	5,053	3,320,607	657	4	7,711	1,928	5,057	3.33
Oklahoma	C	507	1,291,779	2,548	14	45,742	3,267	521	1.34
Oregon	D	9,321	3,003,535	322	55	144,465	2,627	9,376	3.15
Pennsylvania	A	1,587	698,419	440	7	13,321	1,903	1,594	0.71
Puerto Rico	C	1	17	17	0	-	-	1	0.00
Rhode Island	A	183	145,296	794	20	56,723	2,836	203	0.20
South Carolina	C	512	1,604,685	3,134	8	20,653	2,582	520	1.63
South Dakota	D	2,899	573,296	198	120	359,398	2,995	3,019	0.93
Tennessee	C	1,952	1,756,896	900	71	345,141	4,861	2,023	2.10
Texas	C	2,482	5,791,560	2,333	54	212,017	3,926	2,536	6.00
Utah	D	4,251	1,137,554	268	188	533,901	2,840	4,439	1.67
Vermont	A	76	15,793	208	14	55,164	3,940	90	0.07
Virginia	C	68	6,358	94	0	-	-	68	0.01
Washington	D	24,015	5,345,377	223	290	851,230	2,935	24,305	6.20
West Virginia	C	18	5,512	306	0	-	-	18	0.01
Wisconsin	B	109	521,131	4,781	9	30,187	3,354	118	0.55
Wyoming	D	1,684	499,735	297	102	206,728	2,027	1,786	0.71
Other	A	52	17,036	328	43	314,146	7,306	95	0.33
Other	B	2,670	478,744	179	24	21,566	899	2,694	0.50
Other	C	1,198	119,555	100	343	1,115,982	3,254	1,541	1.24
Other	D	16,911	1,450,888	86	1,332	96,550	72	18,243	1.50
Total		**185,065**	**$75,435,474**	**$408**	**6,813**	**$16,899,918**	**$2,481**	**191,878**	**$92.34**

Table B2. Corrections by Recovery Auditor								
Recovery Auditor	*Corrected*						*Total Corrected*	
	Overpayments Collected			*Underpayments Restored*				
	No. of Claims	*Amount ($ Million)*	*Mean Claim Amount ($)*	*No. of Claims*	*Amount ($ Million)*	*Mean Claim Amount ($)*	*No. of Claims*	*Amount ($ Million)*
Region A: DCS	*9,856*	*$ 4.7*	*$475*	*287*	*$ 1.2*	*$4,083*	*10,143*	*$ 5.9*
Region B: CGI	*22,519*	*15.4*	*685*	*71*	*0.1*	*1,831*	*22,590*	*15.5*
Region C: Connolly	*22,244*	*24.4*	*1,096*	*1,033*	*3.2*	*3,063*	*23,277*	*27.5*
Region D: HDI	*130,446*	*30.9*	*237*	*5,422*	*12.4*	*2,293*	*135,868*	*43.4*
Total	*185,065*	*$75.4*	*$408*	*6,813*	*$16.9*	*$2,481*	*191,878*	*$92.3*

Table B3. Corrections by Part A, B, and DME Claims								
Type	*Corrected*						*Total Corrected*	
	Overpayments Collected			*Underpayments Restored*				
	No. of Claims	*Amount ($ Million)*	*Mean Claim Amount ($)*	*No. of Claims*	*Amount ($ Million)*	*Mean Claim Amount ($)*	*No. of Claims*	*Amount ($ Million)*
Part A	*49,199*	*$ 51.1*	*$1,039*	*5,569*	*$ 16.8*	*$3,017*	*54,768*	*$67.9*
Part B	*54,900*	*5.5*	*100*	*1,231*	*0.1*	*80*	*56,131*	*5.6*
DME	*80,966*	*18.8*	*233*	*13*	***	*136*	*80,979*	*18.8*

** indicates an amount less than $25,000*

Table B4. Corrections by Recovery Auditor and Part A, B, and DME Claims

Recovery Auditor	Claim Type	Demanded			Corrected							
					Collected			Restored			Total Corrected	
		No. of Claims	Total ($)	Mean Claim Amount ($)	No. of Claims	Total ($)	Mean Claim Amount ($)	No. of Claims	Total ($)	Mean Claim Amount ($)	No. of Claims	Total ($)
Region A: DCS	Part A	1,575	$5,422,904	$3,443	868	$3,596,894	$4,144	287	$1,171,772	$4,083	1,155	$4,768,666
	Part B	283	33,489	118	468	48,664	104	0	-	-	468	48664
	DME	11,250	1,432,085	127	8,520	1,039,500	122	0	-	-	8,520	1,039,500
Region B: CGI	Part A	20,718	19,161,234	925	19,974	14,980,649	750	66	129,114	1,956	20,040	15,109,763
	Part B	2,701	422,748	157	1,805	331,266	184	5	917	183	1,810	332,183
	DME	3,520	538,623	153	740	105,836	143	0	-	-	740	105,836
Region C: Connolly	Part A	17,323	40,571,168	2,342	14,072	20,643,799	1467	1,020	3,162,598	3,101	15,092	23,806,397
	Part B	106	13,977	132	89	5,057	57	0	-	-	89	5,057
	DME	47,398	9,842,961	208	8,083	3,730,377	462	13	1,764	136	8,096	3,732,141
Region D: HDI	Part A	18,189	21,762,172	1,196	14,285	11,891,663	832	4,196	12,336,189	2,940	18,481	24,227,852
	Part B	118,540	12,575,607	106	52,538	5,087,783	97	1,226	97,565	80	53,764	5,185,348
	DME	73,680	23,909,625	325	63,623	13,973,988	220	0	-	-	63,623	13,973,988
Total		**315,283**	**$135,686,593**	**$430**	**185,065**	**$75,435,476**	**$408**	**6,813**	**$16,899,919**	**$2,481**	**191,878**	**$92,335,395**

Figure B1. Collections by Claim Type

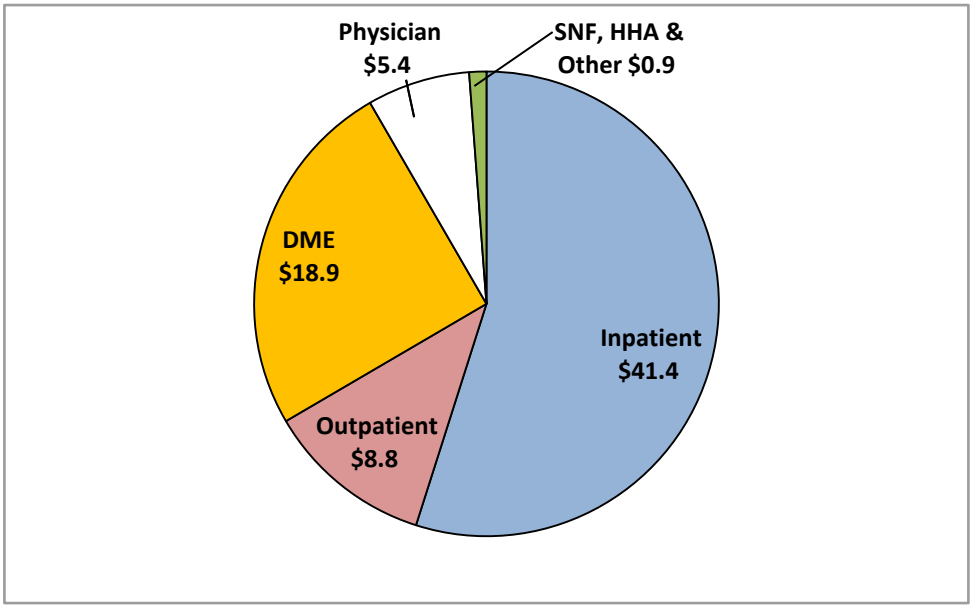


Figure B2. Breakdown of DME Claims (Physician versus Supplier)

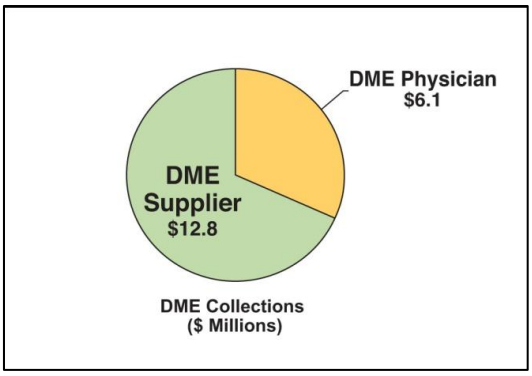
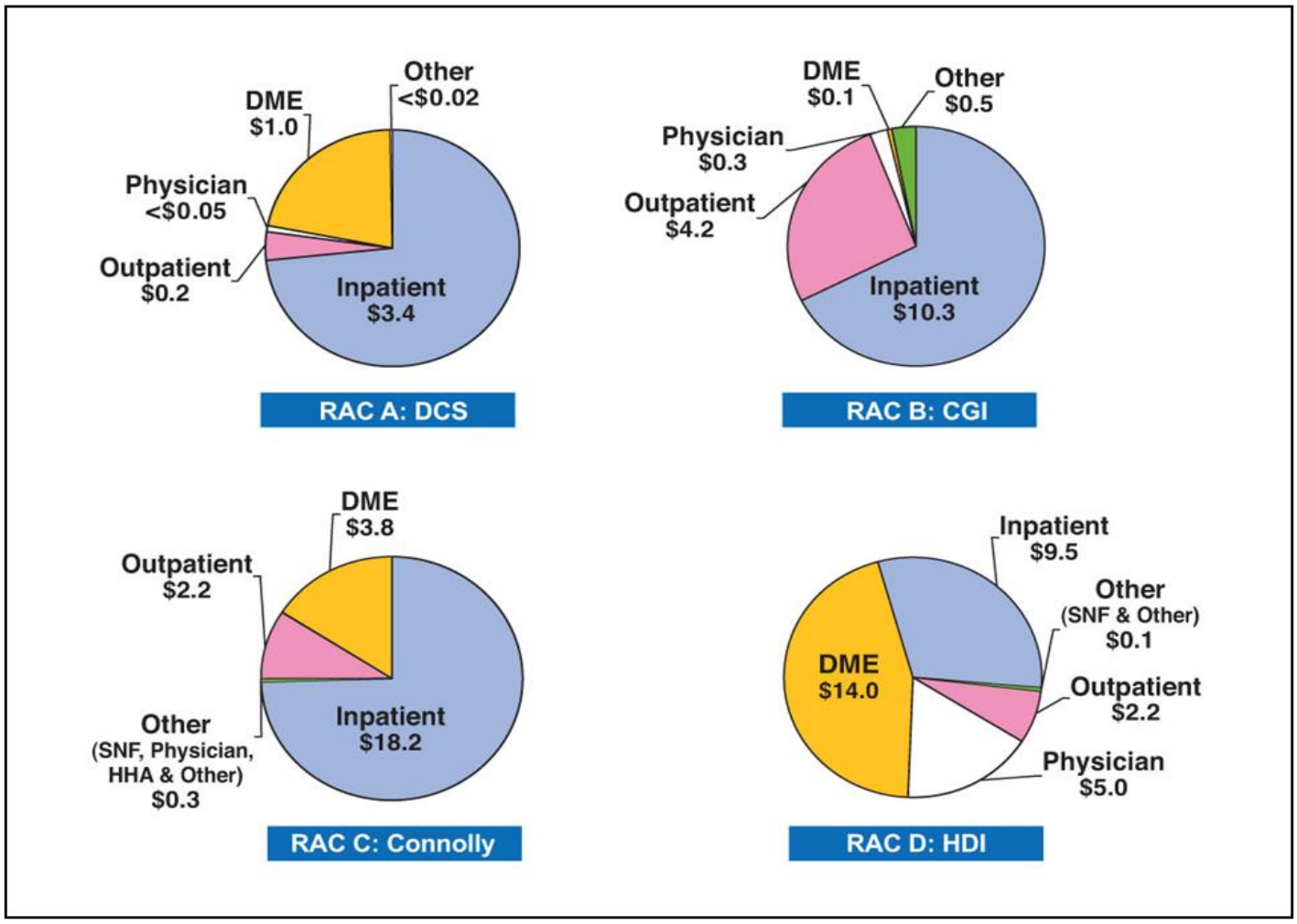


Figure B3. Collections by Claim Type and Recovery Auditor



Appendix C: Issue Codes

Table C1. Top 4 Issue Codes by Recovery Auditor—Collections

Recovery Auditor	Issue Code	No. of Claims	Total ($)	Mean Claim Amount ($)
Region A: DCS	Ventilator 96+ hours–DRG value	93	$ 1,882,615	$ 20,243
	Cardiac procedures–DRG value	45	325,738	7,239
	Cerebrovascular disease (CVA)–DRG value	115	325,043	2,826
	Multiple DME rentals per month	3,408	311,762	91
Region B: CGI	Unrelated extensive procedure	161	$ 1,681,390	$ 10,443
	Tracheostomy overpayment	14	1,339,325	95,666
	IV infusion chemotherapy	6,483	1,290,135	199
	Excisional debridement	140	1,052,100	7,515
Region C: Connolly	Other respiratory system O.R. procedures with MCC	191	$ 2,549,301	$ 13,347
	DME claims billed during inpatient stay	3,409	1,740,973	511
	Coagulation disorder MD–DRG 813	432	1,674,838	3,877
	Respiratory system diagnosis with ventilator support 96+ hours	75	1,549,888	20,665
Region D: HDI	DME–POS during inpatient stay	22,248	$ 6,578,421	$ 296
	Date of service after death–DME	13,874	1,473,640	106
	Prosthetic bundling	2,134	1,328,000	622
	Untimed codes–Excessive units	5,389	1,038,985	193

Table C2. Top 4 Issue Codes by Recovery Auditor—Underpayments				
Recovery Auditor	**Issue Code**	**No. of Claims**	**Total ($)**	**Mean Claim Amount ($)**
Region A: DCS	Cerebrovascular disease (CVA)–DRG value	152	$ 372,462	$ 2,450
	Small and large bowel procedures–DRG value	39	312,229	8,006
	Acute respiratory failure–DRG value	22	71,853	3,266
	Ventilator 96+ hours–DRG value	14	34,002	2,429
Region B: CGI	Respiratory system diagnosis with ventilator support	8	$ 30,393	$ 3,799
	Respiratory system, DRG	2	23,445	11,722
	Heart failure, DRG 127; MS-DRG 291, 292, 293	3	21,456	7,152
	New issue acute respiratory failure, MS-DRG 189	3	7,580	2,527
Region C: Connolly	Skin grafts and wound debridement	48	$ 164,134	$ 3,419
	Extensive O.R. procedure unrelated to principle diagnosis with CC	19	112,666	5,930
	Extensive O.R. procedure unrelated to principal diagnosis	26	112,642	4,332
	Nonextensive O.R. procedure unrelated to principal diagnosis	31	108,263	3,492
Region D: HDI	Incorrect patient status, acute underpayments	3,827	$11,005,078	$ 2,876
	Incorrect patient status, inpatient rehabilitation facility underpayments	171	1,197,021	7,000
	Untimed codes–Excessive units	11	5,204	473
	Blood transfusions–Excessive units	3	2,840	947

Appendix D: Error Codes

Table D1. Top Error Codes for Collections by Recovery Auditor

Recovery Auditor	Error Code	No. of Claims	Total ($)	Mean Claim Amount ($)
Region A: DCS	Incorrect code	1,227	$ 3,171,808	$ 2,585
	Unbundling	3,344	563,485	169
	Non-covered, non-allowed, other	4,611	382,015	83
	Medically unnecessary item(s) or service	495	276,736	559
	Incorrect discharge status	35	157,192	4,491
Region B: CGI	Incorrect number of units	16,798	$ 9,606,678	$ 572
	Incorrect code	374	4,159,492	11,122
	Incorrect Medicare service provider billed	1,508	398,050	264
	Unbundling	417	90,742	218
	Incorrect discharge status	13	60,770	4,675
Region C: Connolly	Incorrect code	2,601	$ 18,164,294	$ 6,984
	Incorrect number of units	11,434	3,219,533	282
	Unbundling	6,963	2,787,660	400
	Non-covered, non-allowed, other	21	44,024	2,096
	Multiple error code values within claim	9	5,567	619
Region D: HDI	Unbundling	61,605	$ 11,835,149	$ 192
	Incorrect code	15,328	5,598,794	365
	Non-covered, non-allowed, other	17,333	2,764,816	160
	Incorrect number of units	12,640	2,366,098	187
	Incorrect discharge status	417	1,772,106	4,250

Table D2. Top Error Codes for Underpayments by Recovery Auditor				
Recovery Auditor	**Error Code**	**No. of Claims**	**Total ($)**	**Mean Claim Amount ($)**
Region A: DCS	Incorrect code	243	$ 857,538	$ 3,529
	Incorrect discharge status	1	88	88
Region B: CGI	Incorrect number of units	32	$ 52,465	$ 1,640
	Incorrect code	11	37,973	3,452
Region C: Connolly	Incorrect code	477	$ 1,973,333	$ 4,137
	Incorrect number of units	208	73,302	352
	Unbundling	4	1,191	298
Region D: HDI	Incorrect discharge status	4,003	$ 12,205,388	$ 3,049
	Incorrect code	62	122,397	1,974
	Incorrect number of units	23	10,535	458
	Non-covered, non-allowed, other	1	60	60
	Unbundling	1	46	46

Appendix E: Appeals

Table E1. Appeals by Type and Recovery Auditor

Recovery Auditor	Type	No. of Claims with Overpayment Determinations	No. of Claims in which Provider Appealed[1]				Claims Appealed by Providers at any Level		Appealed Claims with Decisions in Provider's Favor		Overpayment Determinations Overturned on Appeal (%)
			FI	QIC	ALJ	DAB	No. of Claims	Percent (%)	No. of Claims	Percent (%)	
Region A: DCS	Part A	858	13	-	-	-	13	1.5	-	-	0.0
	Part B	451	-	-	-	-	-	0.0	-	-	0.0
	DME	8,495	256	-	-	-	256	3.0	27	10.5	0.3
Region B: CGI	Part A	17,294	3,539	1	-	-	3,540	20.5	2,119	59.9	12.3
	Part B	1,796	71	-	-	-	71	4.0	49	69.0	2.7
		737	1	-	-	-	1	0.1	1	100.0	0.1
Region C: Connolly	Part A	13,307	772	20	3	-	795	6.0	150	18.9	1.1
	Part B	88	24	-	-	-	24	27.3	-	-	0.0
	DME	7,638	-	-	-	-	-	0.0	-	-	0.0
Region D: HDI	Part A	12,488	628		-	-	628	5.0	285	45.4	2.3
	Part B	36,980	510	5	-	-	515	1.4	28	5.4	0.1
	DME	63,507	2,601	5	-	-	2,606	4.1	1,243	47.7	2.0
Total		**163,639**	**8,415**	**31**	**3**	**-**	**8,449**	**5.2**	**3,902**	**46.2**	**2.4**

[1]The number of claims that have been appealed is limited to claims originating in FY2010, with appeals initiated through 9/30/2010. Each level of the appeal process has statutory timeframes that provide due process to providers. These timeframes extend beyond the end of the fiscal year (e.g., while only 3 FY2010 claims appear as appealed to the ALJ level, ALJs actually heard 484 RAC-related claims in FY2010, most of which originated in the RAC demonstration in prior FYs and are therefore not reflected in Appendix E). Each annual report will include actual claims appealed during the fiscal year at each level.

Appendix F: Accuracy Scores

Table F1. Number of Accuracy Score Reports and Cumulative Accuracy by Recovery Auditor		
Recovery Auditor	**No. of Accuracy Score Reports (Period)**	**Cumulative Score**
Region A: DCS	4* *(12/09 to 4/10)*	98.6
Region B: CGI	4 *(12/09 to 3/10)*	99.2
Region C: Connolly	5 *(11/09 to 3/10)*	97.6
Region D: HDI	5** *(11/09 to 3/10)*	99.4

**DCS's February data is omitted due to insufficient number of claims to sample.*
***HDI added approximately 12,000 records to the February sampling frame, after sample selection. HDI's cumulative accuracy rate may be biased as it adjusts for an unknown impact of these records that were not subject to sampling. It is unknown whether these records differ in significant ways from the records that were eligible for sample selection.*