Medicare Fee-for-Service Recovery Audit Program as of June 2011

	National Program				
	FY 2010 Oct 2009– Sep 2010	**FY 2011 Q1** Oct 2010-Dec 2010	**FY 2011 Q2** Jan 2011-Mar 2011	**FY 2011 Q3** Mar 2011-Jun 2011	**Total National Program**
Overpayments Collected	$75.4 M	$81.2 M	$185.2 M	$233.4 M	$575.2 M
Underpayments Returned	$16.9 M	$13.1 M	$23.7 M	$55.9 M	$109.6 M
Total Corrections	$92.3 M	$94.3 M	$208.9 M	$289.3 M	$684.8 M

The U.S Congress authorized the nationwide expansion of the Recovery Audit program through the Tax Relief and Health Care Act of 2006. Recovery Auditors are CMS contractors who are tasked with detecting and correcting past improper payments.

Top Issue per Recovery Auditor (National Recovery Audit Program: FY 2010– June 17th, 2011)

	Overpayment Issues
Region A: Diversified Collection Services	**Renal and Urinary Tract Disorders**– Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with renal and urinary tract disorders needs to be complete and support all services provided. **(Medical Necessity)**
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	**Minor Surgery and other treatment billed as Inpatient**–When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight. **(Medical Necessity)**