Recovery Auditing in Medicare for Fiscal Year 2013

FY 2013 Report to Congress as Required by Section 1893(h) of the Social Security Act

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Executive Summary

The mission of the Recovery Audit Program is to identify and correct Medicare and Medicaid improper payments through the efficient detection and collection of overpayments made on claims for health care services provided to Medicare and Medicaid beneficiaries, and the identification of underpayments to providers so that the Centers for Medicare & Medicaid Services (CMS) and States can implement actions that will prevent future improper payments.

The CMS oversees several different Recovery Audit Programs, such as those for fee-for-service (FFS) Medicare and Parts C and D. States oversee their own Medicaid Recovery Audit Programs in accordance with federal guidelines set by CMS. The FFS Medicare Recovery Audit Program is authorized under Section 1893(h) of the Social Security Act (the Act). This report focuses only on the FFS Medicare Recovery Audit Program. Information on the other Recovery Audit Programs will be reported separately.

Medicare FFS Recovery Audit Program

The Medicare FFS program consists of a number of payment systems. It has a network of contractors that process more than one billion claims each year, submitted by more than one million healthcare providers, including hospitals, physicians, skilled nursing facilities (SNF), labs, ambulance companies, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. These Medicare contractors, called Medicare Administrative Contractors (MACs), process claims, make payments to providers in accordance with Medicare regulations, and educate providers on how to submit accurately coded claims that meet Medicare guidelines.

The CMS uses several types of contractors to ensure that paid claims are paid based on Medicare guidelines. One type of contractor used is a Recovery Auditor, also known as a Recovery Audit Contractor (RAC). A Recovery Auditor's primary task is to review Medicare claims data and determine if a claim was appropriately paid. Section 1893(h) of the Act authorized the Recovery Audit Program expansion nationwide by January 2010. Prior to this, the Recovery Audit program operated as a demonstration in six states from March 2005 to March 2008. The national Recovery Audit Program was established in early 2009 after conducting a full and open competition. Four contracts were awarded for four distinct regions. 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 common billing errors, trends, and other Medicare payment issues to CMS.

In Fiscal Year (FY) 2013, Recovery Auditors collectively identified and corrected 1,532,249 claims for improper payments, which resulted in $3.75 billion dollars in improper payments being corrected. The total corrections identified include $3.65 billion in overpayments collected and $102.4 million in underpayments repaid to providers and suppliers (see Table 1). After taking into consideration all fees, costs, and first level appeals, the Medicare FFS Recovery Audit Program returned over $3.0 billion to the Medicare Trust Funds (Appendix B). These savings do not take into account program costs and administrative expenses incurred at the third and fourth levels of appeal (Office of Medicare Hearings and Appeals (OMHA) and Medicare Appeals Council within the Departmental Appeals Board (DAB), respectively), as these components do not receive Recovery Audit Program funding for those appeals.

In late FY 2012 CMS implemented a demonstration to use Recovery Auditors for the purpose of reviewing claims before they are paid. FY 2013 was the first full year of the Recovery Auditor Prepayment Review Demonstration. The demonstration started on September 1, 2012 and is scheduled for three years in the following 11 states: Florida, California, Michigan, Texas, New York, Louisiana, Illinois, Pennsylvania, Ohio, North Carolina, and Missouri. The goal of the demonstration is to lower the number of improper payments for those claims, which are shown through Comprehensive Error Rate Testing (CERT) reports and other data analysis to have high rates of improper payments. Through this demonstration, the Recovery Auditors have prevented $22.3 million in improper payments by reviewing claims before they were paid. After a successful first-year, CMS has started evaluating the effectiveness of the demonstration and including additional error-prone services for review.

The CMS uses the results of audits performed by the Recovery Auditors to identify program vulnerabilities and take appropriate corrective actions to prevent future improper payments. The CMS hosts regular meetings with the Recovery Auditors, MACs, and CMS staff to discuss best practices, as well as particular vulnerabilities and future corrective actions ranging from CMS educational articles, local and national system edits, and additional review by other entities. The CMS continues to analyze the results of the Recovery Audit program to determine what corrective actions can be implemented to help reduce improper payments in the future.

The CMS continues to make improvements to the Recovery Audit program to help alleviate provider burden, ensure the accuracy of Recovery Auditor determinations, and promote transparency within the program. All Recovery Auditors have increased their use of the Electronic Submission of Medical Documentation (esMD) system to facilitate the transmission of medical documentation and help eliminate the costly and time-consuming need for providers to mail paper records for contractor review. The CMS is increasing collaboration between the Recovery Auditors and the MACs on many program elements such as data sharing and reporting, policy and coverage interpretation, appeals, and general operational issues and improvements. To aid in the appeal process, CMS has also been working with the Recovery Auditors to encourage further involvement in the appeals process, specifically at the Administrative Law Judge (ALJ) level of appeal. The Recovery Auditors are involved in appeals meetings between other CMS review entities, such as MACs and Zone Program Integrity Contractors (ZPICs) and CMS appeals contractors such as the Qualified Independent Contractors (QICs) and the Administrative QIC (AdQIC) to discuss trends in appeals, as well as best practices for creating position papers to use at ALJ hearings. Involvement by Recovery Auditors in ALJ appeals aids in contractor and provider education, as it presents a forum for discussion, and can identify erroneous billing practices to the provider and policies that need clarification.

In accordance with the President's initiative to eliminate waste and improper payments across federal programs, the Medicare FFS Recovery Audit Program has proven to be a valuable tool to reduce improper payments.

Introduction

Background

Faced with increasing national health expenditures and a growing beneficiary population, the importance and challenges of safeguarding the Medicare program are greater than ever.

The CMS uses a comprehensive strategy to prevent and reduce improper payments. Each year, CMS publishes a national error rate for Medicare FFS, Part C, Part D, Medicaid, and the Childrens Health Insurance Program (CHIP) in accordance with the *Improper Payments Information Act of 2002 (IPIA)*, as amended by the *Improper Payments Elimination and Recovery Act of 2010 (IPERA)* and the *Improper Payments Elimination and Recovery Improvement Act of 2013 (IPERIA)*.[1]

As part of its efforts to implement the IPIA, the CMS uses the CERT program to identify areas that may be vulnerable for improper payments in Medicare FFS. CMS uses these results to direct future work by the Medicare FFS Recovery Audit program and the MACs[2].

In addition, each MAC is required to complete an Error Rate Reduction Plan (ERRP) that includes jurisdictional level strategies to reduce improper payments. These plans include the standard additional review and clarification of local and national policies as well as new and innovative ideas for reducing improper payments. These plans are targeted to potential claims that, based on data analysis, may be improper. Additional provider education, widespread or localized, is included, as well as clarifications and modifications to local coverage policies. These plans have proven to be successful in helping to reduce each MAC's error rate. The ZPICs provide additional protections for reducing improper payments by identifying and investigating areas of potential fraud, including those referred to them by MACs and Recovery Auditors. When warranted, ZPICs report providers and claims to law enforcement authorities who specialize in fraud, waste, and abuse prevention.

While several Medicare contractors are responsible for auditing Medicare claims, CMS has processes in place to ensure the work is collaborative and not duplicative. A claim that has been reviewed by one entity is not available to another entity for review, absent potential fraud. Any claim or provider currently being reviewed for potential fraud is usually not available for review by a Recovery Auditor and the contractors work together to ensure they all are not reviewing the same issues for the same providers. CMS is continuously working to improve the collaboration between auditing contractors to ensure accurate and efficient auditing of Medicare claims while reducing provider burden and ensuring beneficiary access to health care/health services.

Improper Payments in Medicare

Claims submitted to Medicare are screened by thousands of system edits prior to payment; however, due to the large volume of claims submitted, most are generally paid without requesting and reviewing the

[1] Additional information about the Medicare Fee-for-Service national error rate can be found at go.cms.gov/CERT Additional information about the Medicaid national error rate can be found at go.cms.gov/PERM

[2] Effects of Recovery Auditor reviews may not be immediately realized in the CERT report, due to differences in the Recovery Auditor look back period and the CERT reporting period.

medical records to support the services billed. As a result, claims may be paid inappropriately, resulting in improper payments.

The most common reasons for improper payments are the following:

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

Given the volume of claims submitted to Medicare on a daily basis, CMS is not able to perform 100 percent medical review prior to payment, commonly referred to as prepayment review. CMS must rely on conducting medical record review after payment, commonly referred to as postpayment review. Overall, CMS manually reviews less than 0.3 percent of submitted claims each year through programs such as the Recovery Audit Program.

Statutory Authority for Recovery Auditors

The Medicare FFS Recovery Audit Program began as a demonstration required in the Medicare Prescription Drug, Improvement and Modernization Act of 2003[3]. The 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. This demonstration allowed for additional review of Medicare claims for payment by utilizing Recovery Auditors on a contingency fee basis to identify and investigate claims with calculated risk. The Recovery Audit demonstration established Recovery Auditors as a successful tool in the identification and prevention of improper Medicare payments.

Section 1893(h) of the Act authorized the Recovery Audit Program expansion nationwide by January 2010 (Appendix A). This requires 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. This report satisfies that requirement.

The Use of Recovery Auditors

The Recovery Audit Program is an important initiative in CMS's goal to reduce improper payments and pay claims accurately. The CMS established the Recovery Audit Program in early 2009 and fully implemented the program by September 2010. 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. Recovery Auditors are unique and distinct from other contractors due to their ability to conduct widespread post-payment review.

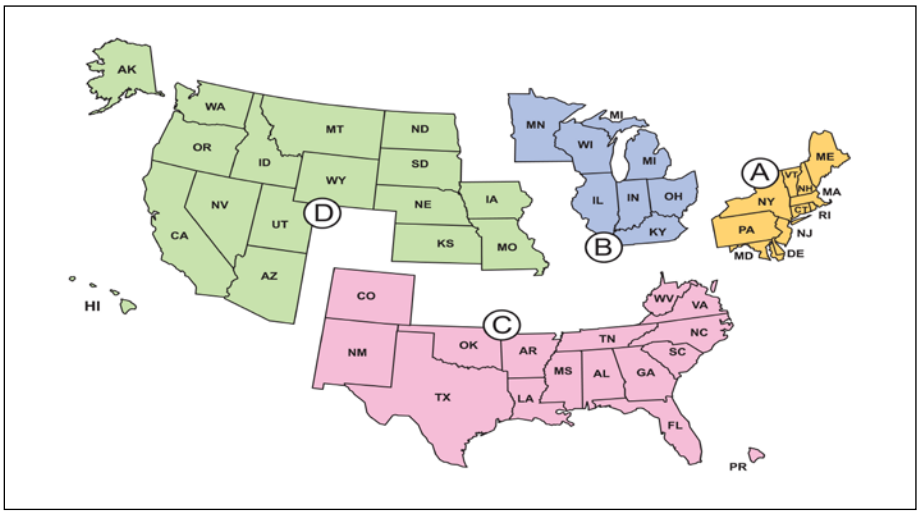
[3] For more information on the Recovery Audit program demonstration see http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Historical_Programs.html

The Recovery Auditors in each region in FY 2013 were:

- Region A: Performant Recovery
- Region B: CGI
- Region C: Connolly
- Region D: HealthData Insights (HDI)

Figure 1 depicts each of the four Recovery Audit Program regions.

Figure 1:



How Recovery Auditors are Paid

Recovery Auditors are paid on a contingency fee basis. The amount of the contingency fee is a percentage of the improper payment recovered from, or reimbursed to providers. The Recovery Auditors negotiate their contingency fees at the time of the contract award. The base contingency fees ranged from 9.0-12.5 percent for all claim types except DME. The contingency fees for DME claims ranged from 14.0 -17.5 percent. The Recovery Auditor must return the fee if an improper payment determination is overturned at any level of appeal.

Recovery Audit Review Process

The Recovery Auditors review Medicare FFS claims on a postpayment[4] basis using the same Medicare policies and regulations as other Medicare contractors. The CMS limits the claims eligible for Recovery Auditor review to those that were paid within the past three years. The Recovery Auditor improper payment correction process is similar to that used by other Medicare contractors and is as follows:

Review

Recovery Auditors follow three review processes to identify improper payments: automated, semi-automated, and complex.

- **Automated**: These reviews use claims data analysis to identify improper payments.
- **Semi-Automated**: Similar to automated, these reviews are initiated with data analysis; however, providers may submit supporting documentation to substantiate the claim.
- **Complex**: These reviews require a review of the supporting medical records to determine whether there is an improper payment. The reviewer must be a qualified health care coder or clinician, based on the type of review being undertaken.

Notification

After the Recovery Auditor identifies an improper payment, the next step in the process is notifying the provider of the overpayment or underpayment. For automated and semi-automated reviews, the Recovery Auditors send informational letters that describe the rationale for the overpayment determination. For claims that underwent a complex review, Recovery Auditors are required to send review results letters with more detailed rationales, indicating the specific reason for the improper payment determination. Review results letters also include references utilized in reviewing the medical documents and educate providers about how to avoid similar payment errors in future Medicare billing practices.

After notification of an improper payment, providers may request a discussion with the Recovery Auditors regarding their claim determinations. The discussion period offers providers the opportunity to submit additional documentation to substantiate their claims, and allows the Recovery Auditors to review the additional information without the provider having to file an appeal. If the Recovery Auditor reverses its claim determination, it will stop the claim from being adjusted, or work with the MAC to reverse the adjustment if it has already occurred. However, providers may not simultaneously initiate a discussion and an appeal. The Recovery Auditors will stop the discussion period if they are notified of a pending appeal.

In the case of an underpayment, the provider is notified via letter describing the underpayment and the repayment process. In the case of an overpayment, the provider receives a demand letter requesting repayment of the specific amount. The demand letter includes the accompanying rationale for the determination and instructs providers on the repayment and appeal processes. The MACs have full responsibility of issuing demand letters related to Recovery Auditor-initiated overpayments. This

[4] See page 15 for a discussion of the Recovery Auditor prepayment review demonstration.

streamlines all adjustment correspondence and activities and ensures the timeliness of demand notifications.

Collection and Repayment

The MACs are responsible for the collection efforts of overpayments and repayment of underpayments identified by the Recovery Auditors. The recoupment of an overpayment may be offset against future payments from CMS if payment is not received within the specified timeframe. The provider may also apply for an extended repayment plan. Typically, recoupment from future payments begins 41 days after the adjustment/date of the demand letter. In addition, the receipt of a valid appeal may also delay recoupment.

Appeals

Providers who disagree with a Recovery Auditor's improper payment determination may utilize the multilevel administrative appeals process. Recovery Audit appeals follow the same appeal process as other Medicare claim determinations. The levels of appeal are described below.

Redetermination:

Performed by MACs, this appeal must be received within 120 days of the initial determination, and decided by the contractor within 60 days of receipt.

Reconsideration:

Performed by Qualified Independent Contractors (QICs), this appeal must be filed within 180 days of the date of the Medicare Redetermination Notice. The QICs have 60 days to process the appeal.

Administrative Law Judge (ALJ):

ALJ appeals require a minimum amount in controversy (currently $140), and must be filed within 60 days of the reconsideration notice. Generally, ALJs must issue a decision, dismissal order, or remand to the QIC within 90 calendar days (if the ALJ does not act in a timely manner, the appellant may file a request for DAB review); however, due to increases in overall appeals filed, including increases in appeals of Recovery Auditor determinations, adjudication timeframes have generally been exceeding 90 calendar days.[5]

Medicare Appeals Council within the DAB:
This level of appeal must be filed within 60 days of the ALJ decision, and is generally decided within 90 days of the request. There is no minimum amount in controversy at this level[6].

Final Judicial Review (Federal District Court Review):

The current minimum amount in controversy for this level is $1,350. The appeal must be filed within 60 days of the appeals council notice, but the federal court does not have a deadline for its review.

[5] Operational expenses of appeals filed at this level are not funded through the Recovery Audit Program and recovery amounts are not reduced by appeal expenses at this level.
[6] Operational expenses of appeals filed at this level are not funded through the Recovery Audit Program and recovery amounts are not reduced by appeal expenses at this level.

Prepayment Review

As part of the prepayment demonstration that was approved and implemented in late FY 2012, Recovery Auditors started reviewing certain error-prone claims before they were paid. In collaboration with the MACs, CMS implemented claims processing edits that would flag some claims for further review. Providers who billed these claims receive additional documentation request letters to send in their medical records for review. After review, the Recovery Auditors send a review results letter to the provider, and communicate with the MACs as to whether the claim should be paid or denied. Providers may still appeal these claims, and they are generally off limits for further postpayment reviews. More information on the Prepayment Review Demonstration can be found in the Results Section on page 15.

Key Program Components

The CMS has identified five key factors for measuring the success of the Recovery Audit Program: ensuring accuracy, ensuring the program operates efficiently and effectively, maximizing transparency, minimizing provider burden, and developing robust provider education. In addition, communication with key stakeholders is essential to the program's success, as it ensures that problems and solutions are identified early and that issues are discussed with all parties.

Ensuring Accuracy

The CMS has implemented several elements to ensure Recovery Auditors are accurately identifying improper payments. All new review topics for potential audits are approved by CMS before the Recovery Auditors begin widespread review. For some complex non-coding reviews, this occurs through a CMS New Issue Review Board that is comprised of CMS policy and coverage staff and clinicians. This ensures that the appropriate CMS personnel both are aware of and approve of what the Recovery Auditors are reviewing, and that they have the correct interpretation of the policies used in their audit methodologies. During CMS New Issue Board meetings, coverage and policy experts review whether the Recovery Auditor's proposed review approach is consistent with current guidelines. These discussions sometimes reveal that certain guidelines may be outdated or no longer clinically appropriate. This leads to changes in updating certain coverage or billing guidelines to align with more current practice.

For other types of reviews, such as automated, semi-automated, and complex coding, CMS uses the expertise of the MACs to review potential review topics and make recommendations to CMS regarding approval. This ensures that the contractor that implemented the policy is aware of the audit and that the Recovery Auditors are correctly interpreting the policies in their region.

Recovery Auditors are also required to have at least one full time Contractor Medical Director (CMD) on staff. The use of CMDs has proven to be a valuable addition to the program, as they provide clinical expertise on and oversight of the medical review process. The CMD is required to be involved in all phases of the medical review and quality assurance processes to ensure that policies are being followed and accurate review decisions are being made. The CMD participates in policy discussions with CMS and other Medicare contractors and offers solutions to the improper payment findings. These physicians also engage in frequent discussions with providers, which allows for greater education. Several Recovery Auditors have added additional full- time or part- time CMDs to provide greater clinical guidance and assistance to staff, providers, and CMS. Recovery Auditors also sometimes utilize specialists that are not dedicated to the Recovery Audit Program, but act as resources when needed.

To ensure the accuracy of the Recovery Auditor's claim determinations, CMS uses an independent validation contractor to review a monthly random sample of claims on which a Recovery Auditor has made an improper payment determination. The Recovery Audit Validation Contractor (RVC) establishes an annual accuracy score for each Recovery Auditor. The RVC employs policy experts and clinicians, and presents CMS with an independent decision regarding the sample. The accuracy score represents how often the Recovery Auditors were accurately determining overpayments or underpayments based on the validation contractor's review. In FY 2013, all Recovery Auditors had a cumulative accuracy score of 92 percent or higher (see Appendix J).

The RVC is also tasked with conducting special studies of Recovery Auditor findings. In FY 2013, the validation contractor performed 17 special studies on claims reviewed by all four Recovery Auditors. The CMS uses these studies to further focus on certain claim types and audit areas that may require more analysis. Including both the accuracy and special study reviews, the RVC reviewed over 4,100 claims as part of its oversight activities.

Ensuring the Program Operates Efficiently and Effectively

The CMS works to make the Recovery Audit Program as efficient and effective as possible by minimizing provider impact and administrative cost.

One of the keys to improving efficiencies is continued communication between all stakeholders. The CMS provides several opportunities for discussion among contractors to address operational issues and concerns that may impede program efficiency. In the last year, CMS has increased these communication opportunities and hosts regularly scheduled conference calls for the Recovery Auditors and MACs to discuss ongoing issues. Increased contractor relations have resulted in more streamlined claim processing, changes in the operational process to allow for more efficient communications, and contractor sharing of identified program vulnerabilities for potential review.

The CMS also continues to improve the Recovery Auditor Data Warehouse to track greater audit detail and information. The Data Warehouse was developed to serve as the primary source of data for the Medicare FFS Recovery Audit Program. The CMS uses the Data Warehouse to ensure that Recovery Auditors do not review claims previously subjected to medical record review by another review entity, such as a MAC, or that are currently under review by law enforcement. The CMS continues to improve the warehouse functionalities to allow more data storage and collection, and to automate the process of data collection as much as possible. In FY 2013 CMS implemented several systems changes to allow for more reporting of MAC and ZPIC reviews. These included both prepayment and postpayment data. The CMS also hosts regular communications dedicated to Data Warehouse operational issues.

The CMS is continuing to use esMD to allow providers to electronically submit documentation. In an increasingly electronic medical record environment, this eliminates the costly and time-consuming need for providers to mail hard-copy records for contractor review. In FY 2013, all Recovery Auditors were voluntary participants in the program.

Maximizing Transparency

In order to promote transparency, CMS posts improper payment corrections information, including overpayments and underpayments, on a quarterly basis on its website.[7] CMS also posts the Recovery Auditor statement of work and educational articles aimed at preventing future improper payments. The individual Recovery Auditor websites contain all of the topics approved for review, called "issues," with search functions to improve the ease of provider navigation.

Recovery Auditors are required to use web portals to allow providers to review claim status information and track the progress of their audits. Recovery Auditors have expanded their use of the portals to include demand letter information and review rationales for their improper payment determinations.

[7] This information is posted at go.cms.gov/RAC.

Some Recovery Auditors also use the portal to deliver messages to the provider communities in their region about specific audits, such as details about an audit that may have been stopped, discussion period instructions, and other information that may be helpful to providers as they respond to a request for additional documentation.

The CMS meets regularly with national, state, and local provider and supplier associations as well as other interested stakeholders to discuss operational concerns about the Recovery Audit Program. New ideas and improvements are often discussed at these meetings and CMS values the input of the associations and the providers on the aspects of the program.

Minimizing Provider Burden

The CMS is sensitive to the concerns of the provider and supplier communities and continues to work with these communities to reduce the burden of the review process. The CMS has imposed additional documentation request limits on the number of medical records a Recovery Auditor may request in a 45-day timeframe. The CMS has amended the limits so that requests must be spread across several different provider types, as opposed to requesting only one type of record for a practice/facility. For example, if a provider has inpatient hospital, outpatient hospital, inpatient rehabilitation facility, and physician claims, the Recovery Auditor may only select the maximum percentage of inpatient hospital claims (or any other one particular claim type), and the balance of the additional documentation requests (ADRs) may be selected from the remaining claim types. The limits establish continuity and help providers prepare for potential audits, as well as encourage the Recovery Auditors to select only those claims with the highest risk of improper payment. Appendix I shows the rate of which ADRs result in improper payments for each Recovery Auditor. The CMS continues to analyze provider billing data in an effort to more fairly calculate the ADR limits.

As previously discussed, all Recovery Auditors accept esMD submissions to minimize provider and supplier burden associated with medical documentation requests. The limits and the acceptance of esMD help to minimize the time necessary to respond to Recovery Auditor requests and offers another alternative for providers to safely and quickly transport the documentation. The CMS understands that additional staffing is often required to address Recovery Auditor correspondence and it is constantly working to ensure providers can respond to requests without affecting beneficiary care.

Each Recovery Auditor has a customer service center with representatives available to address provider concerns. They are required to have a quality assurance program to ensure that all customers receive professional and knowledgeable assistance with timely follow up when necessary. Personnel are required to return telephone calls within 1 day, respond to electronic inquiries within 2 days, and respond to written requests within 30 days. The MACs are also available to address any Recovery Audit program questions dealing with claims adjustment, recoupment, and appeals.

In addition to efforts in the Recovery Audit Program, CMS works across the agency to minimize provider burden. These efforts include ensuring that claims reviewed by one entity are not reviewed by another contractor again, unless there is a concern of potential fraud. CMS also works to ensure that multiple review entities such as Recovery Auditors, MACs, and ZPICs are not reviewing the same providers and the same topics at the same time. The CMS is exploring additional options to help providers navigate through the audit process. Initiatives include enhancing CMS websites with consolidated contractor information, standardizing documentation request letters, and standardizing medical review timeframes.

The CMS understands that some providers utilize additional staffing to help manage the requirements of the Recovery Audit Program and is constantly working to streamline program operations as much as possible.

Developing Robust Provider Education

The Recovery Audit program identifies areas for potential improper payments and offers an opportunity to provide feedback to providers on future improper payment prevention. The CMS encourages collaboration between Recovery Auditors and MACs to discuss improvements, areas for possible review, and corrective actions that could prevent improper payments. Educational efforts include articles or bulletins providing narrative descriptions of the claim errors identified and suggestions for their prevention, as well as system edits for errors that can be automatically prevented at the onset. These efforts are described more in the Corrective Action section of this report.

The CMS hosts regular conference calls between the Recovery Auditors, MACs, and CMS policy and clinical staff to discuss audits that have resulted in large amounts of improper payments and present vulnerabilities to the Medicare trust funds. These discussions help to ensure uniformity in policy application, and examine methods for correction and future trust fund protection. CMS and other contractors use these calls to discuss future corrective actions, whether local system edits and/or education can be effective, or if national system edits or education is necessary.

In addition, CMS has partnered with state and national hospital associations to provide periodic updates via conferences, webinars, and teleconferences. These forums serve as an opportunity for CMS to gain the insight of the provider community as well as provide feedback from the program to providers.

FY 2013 Results

Overview

In FY 2013, the Recovery Auditors identified and corrected $3.75 billion in improper payments. There were $3.65 billion collected in overpayments and $102.4 million in identified underpayments paid back to providers (see Table 1).

Table 1

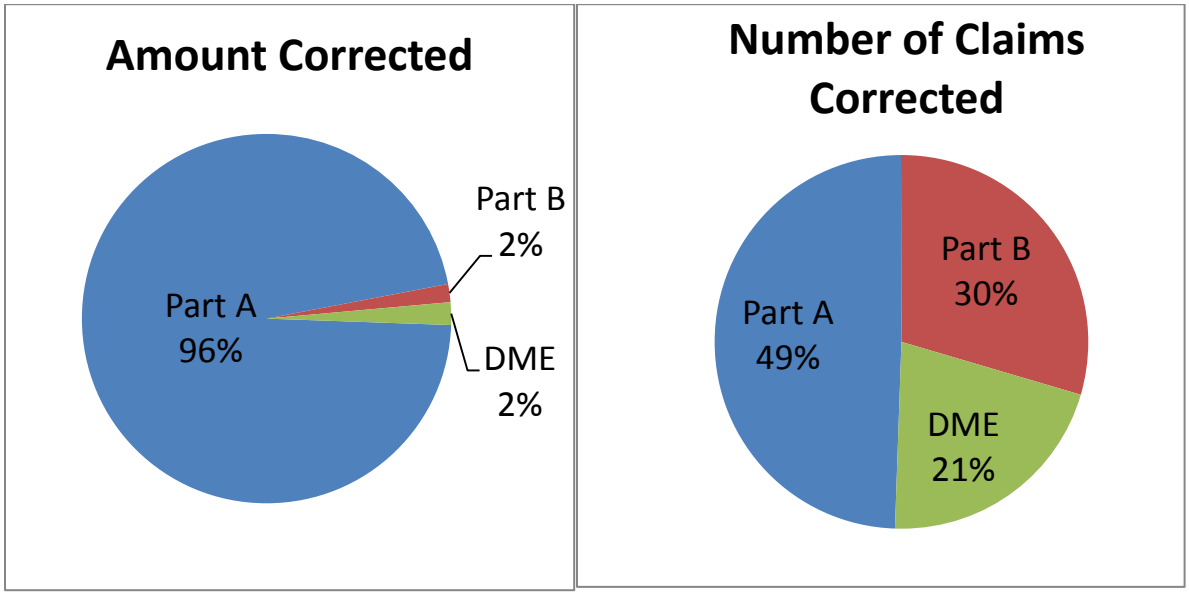
Corrections by Recovery Auditor						
	Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	No. of Claims	Amount Collected	No. of Claims	Amount Restored	No. of Claims	Amount Corrected
Performant	365,435	$762,312,114	3,823	$14,708,223	369,258	$777,020,336
CGI	132,787	$528,731,497	2,416	$7,781,593	135,203	$536,513,091
Connolly	537,690	$1,219,049,512	23,203	$48,358,754	560,893	$1,267,408,266
HDI	453,622	$1,140,666,285	13,167	$31,521,627	466,789	$1,172,187,913
Unknown[8]	104	$155,217	2	$38,307	106	$193,524
Total	***1,489,638***	***$3,650,914,625***	***42,611***	***$102,408,504***	***1,532,249***	***$3,753,323,129***

After taking into consideration all costs to oversee the Recovery Audit Program, underpayment determinations that are paid to providers, and appeal reversals, the Medicare FFS Recovery Audit Program returned $3.03 billion to the Medicare trust funds in FY 2013 (see Appendix B). The CMS spent $454.1 million to operate the Medicare FFS Recovery Audit Program, of which $301.7 million were contingency fees paid to Recovery Auditors. Administrative costs such as processing appeals, adjusting claims, support contractors, and oversight of the program accounted for the additional $152.4 million. Administrative costs do not include the operational costs to OMHA and the DAB for processing Recovery Audit Program appeals. Because the amount of improper payments that were identified in FY 2013 increased significantly over the previous year, contingency fees and the costs to process the additional claims and appeals increased as well.

Compared to overall FFS expenditures, the amount collected by Recovery Auditors is relatively small. Recovery Auditors collected less than 1 percent of the over $481 billion that Medicare pays in Part A and B benefits in FY 2013(Appendices D2 and D3).

The Region C Recovery Auditor, Connolly, had the most corrections in terms of both overpayments and underpayments. See Appendix C for corrections information broken down by each state. Figure 2 shows that the majority of improper payments in FY 2013 were from Part A claims, with two percent each coming from Part B and DME claims. Appendix E shows the breakdown of improper payment corrections by both claim type and Recovery Auditor.

Figure 2



Over 94 percent of these overpayments (more than $3.4 billion) are from inpatient hospital claims (Appendices F and G). Many of the top overpayment determinations in FY 2013 were due to short-stay inpatient hospital admissions. Many short-stay inpatient hospital services should have been provided in the outpatient setting and the documentation fails to demonstrate medical necessity for the inpatient setting. These admissions also represent a significant portion of Medicare's FFS error rate. The CMS has implemented several policy clarifications and modifications to help reduce these types of errors, which are discussed more in-depth in the next section of this report.

Although the Recovery Auditors performed more automated reviews (over 56 percent) than semi-automated and complex reviews, the vast majority of the improper payments collected came from complex reviews (over 95 percent). Appendix H shows more information about the improper payment and claim corrections by the type of review performed.

Appeals

CMS strives to lower the appeal rate to decrease provider burden and administrative costs of the program. In FY 2013, providers initially appealed 500,629 claims, which constituted 30.7 percent of all claims with overpayment determinations (Appendix K1). Throughout all levels of appeal, providers appealed 836,849 claims. Of the total claims appealed, 151,645 claims were overturned with decisions in the

provider's favor (18.1 percent). Overall, only 9.3 percent of all Recovery Auditor determinations were challenged and later overturned on appeal in FY 2013 (see Appendix K5).

Appeals are overturned for a variety of reasons including:

- ALJs are bound by Medicare statute, National Coverage Determinations (NCDs), and CMS rulings. ALJs are required to provide deference to, but are not bound by, CMS manuals or Local Coverage Determinations (LCDs). By contrast, Recovery Auditors are required to make their claim decisions based on all CMS policies including manuals and LCDs. This creates discrepancies between the ALJ decisions and the Recovery Auditor decisions. [9]
- In many Part B denials providers can easily correct and resubmit some claims after the overpayment determination. For example, they can add a missing modifier to the claim that makes it payable.
- Providers often produce additional documentation that was not provided to the Recovery Auditors at the time they made their original decision. Recovery Auditors give providers multiple attempts to provide documentation supporting their claim. However, it sometimes is only produced when a provider receives an overpayment determination and then subsequently files an appeal.

The receipt of an appeal and the reversal of a Recovery Auditor decision do not necessarily mean the Recovery Auditor was incorrect in its determination. Automated and semi-automated reviews are often denied correctly. However, as noted above, the provider can correct the claim during the appeals process by adding a modifier, correcting the number of units of service, or modifying the claim so that it follows CMS policy for payment. In these cases, the Recovery Auditor was correct in its determination. The CMS believes these corrections should be reported as a separate category and continues to improve data sharing and reporting capabilities between contractors to try and account for these corrections.

The CMS has made changes to the review approval process to even further improve the Recovery Auditors' identifications, as well as the appeals overturn rate. The CMS now requires the MACs to validate the Recovery Auditors' proposed review methodology and policy interpretations for their particular jurisdictions to minimize incorrect findings. While the review approval process should minimize these occurrences, CMS works quickly to resolve the issues so the provider can avoid the burden of the appeals process when they do occur.

Recovery Auditors continued to increase their participation in ALJ appeal hearings. Appeals involvement by Recovery Auditors aids in contractor and provider education, as it presents an additional forum for discussion and can identify incorrect billing practices to the provider and CMS policies in need of further clarification. This also presents an opportunity for the Recovery Auditors to clarify any policy questions the ALJ(s) may have during the hearing process.

Short-Stay Inpatient Hospital Admission Claims

The majority of the FY 2013 Recovery Audit Program appeals at the ALJ level focused on short-stay inpatient hospital claims that had overpayment determinations based on inpatient admissions that were not medically necessary. The Recovery Auditor determined from the medical documentation that it was not medically necessary for the patient to be admitted as a hospital inpatient because the patient could

[9] http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf

have been safely and effectively treated as an outpatient. Increased appeals for these types of claims have contributed to backlogs at OMHA, the agency that oversees the third level of appeals. OMHA has a number of options when considering an appeal, including:

- Issuing a fully favorable decision based on the evidence submitted in the administrative record;
- Conducting a video, telephone, or in-person hearing for all parties and participants of the case; or
- Under certain circumstances, remanding the case back to the QIC if evidence is missing from the administrative record.

Medicare policy prior to the CMS Ruling 1455-R (78 FR 16614) allowed providers who received the type of inpatient admission denials described above to only rebill for a limited number of ancillary Part B services. However, many ALJs have ordered payment for all reasonable and necessary Part B services that would have been provided if the patient received services as an outpatient for these admissions that were denied. Although these decisions are considered favorable to the provider, these ALJs agreed with the Recovery Auditor's determinations that the inpatient admissions were not reasonable and necessary. Many other appeals have been remanded back to the QICs for them to determine the difference in payment between the incorrect inpatient hospital setting and the correct outpatient hospital setting.

The CMS took a number of steps to help address the confusion surrounding this issue, as well as reduce the number of these appeals. The CMS issued Ruling 1455–R (78 FR 16614) on March 13, 2013, which expanded rebilling for Part B services. Specifically, it provided that, when a Part A claim for a hospital inpatient admission is denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, the hospital may submit a Part B inpatient claim for payment for the services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient. In addition, the ruling established a standard process for effectuating the DAB and ALJ decisions requiring rebilling of denied Part A inpatient hospital claims under Part B, and addressed the scope of administrative review in these and other, similar cases. This ruling was intended as an interim measure until CMS finalized policies to address the issues raised by these decisions going forward.

CMS solicited public comments in the CY 2013 Hospital Outpatient Prospective Payment System (OPPS) proposed rule on potential clarifications or changes to policies regarding patient status. In response, CMS has released several policies pertaining to this issue. As part of the FY 2014 Hospital Inpatient Prospective Payment System (IPPS) final rule (78 FR 50495), CMS clarified policy regarding when a Medicare beneficiary should generally be admitted as a hospital inpatient and how review contractors will review hospital inpatient claims for payment purposes. In addition, CMS revised its Part B inpatient payment policy to allow payment under Part B for hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient. Under the final rule, CMS specified that a 1-year timely filing restriction will apply to the billing of all Part B inpatient services. The admissions guidance and rebilling policies released as part of the FY 2014 IPPS final rule will become effective, and Ruling 1455-R described above will become inapplicable, for dates of admission on or after October 1, 2013. The provisions published as part of this final rule should result in greater consistency in hospital billing and, as a result, reduce the incidence of improper payments in the Medicare FFS program, which in turn reduces the number of appeals resulting from those improper payments.

Prepayment Review Demonstration

In September 2012, CMS began allowing Recovery Auditors to review claims before they are paid as part of the Recovery Auditor Prepayment Review Demonstration. The demonstration is being conducted in seven states with high incidences of improper payments and fraud (Florida, California, Michigan, Texas, New York, Louisiana and Illinois), as well as four states with the high numbers of short hospital stays (Pennsylvania, Ohio, North Carolina and Missouri). The CMS first instructed the Recovery Auditors to review short-stay inpatient hospital claims. Medicare Severity – Diagnosis Related Groups (MS-DRGs) were selected for review based on CERT data. Certain claims in these states containing a selected MS-DRG are flagged for review before the claim is paid. Therapy claim reviews were added to the Prepayment Demonstration on April 1, 2013 (see Outpatient Therapy Reviews below).

The Recovery Auditors review the submitted documentation for the selected claims before they are paid to ensure that the provider has complied with all CMS coverage and billing rules. If the Recovery Auditor review finds that the claim is billed correctly, then the claim is paid. If the claim is not billed correctly then it is denied. The Recovery Auditor receives its contingency fee on the amount of the claim it prevented from being improperly paid.

A goal of this 3-year demonstration is to lower the number of improper payments for these claims identified through the CERT Error Rate data. During this time, CMS will assess the impact on the provider community before permanent policy changes are implemented. The Recovery Auditors have been reviewing prepayment claims for one year and CMS has just entered the initial stage of evaluating the effectiveness of the demonstration.

The Recovery Auditors are required to complete the review of these claims within 30 days of receiving the documentation. As a result, the approved claims are paid in a timely manner. As of September 21, 2013 over 9,300 claims that met the following criteria were selected for prepayment review as part of this demonstration:

- The claim was from one of the applicable demonstration states
- The length of stay was two days or less
- Every 6th claim was suspended for review

The following MS-DRGs were reviewed during the first year of the program[10]:

- 312 - Syncope and Collapse
- 069 - Transient Ischemia
- 377, 378 and 379 - G.I. Hemorrhage
- 637, 638 and 639 - Diabetes
- 252, 253 and 254 - Other Vascular Procedures
- 391 and 392 - Esophagitis, Gastroenteritis and Misc. Digestive Disorders

[10] Patient status reviews for short-stay inpatient hospital claims were stopped on October 1, 2013 with the implementation of the FY 2014 Hospital Inpatient Prospective Payment System (IPPS) Final Rule.

Over 58% of the reviewed claims were improperly billed, which resulted in $22.3 million in savings to the Medicare Trust Fund, illustrating the importance of this demonstration. Appeals data on demonstration claims are limited at this time, as these claims have yet to proceed through multiple levels of appeals. It is not anticipated that the appeals rate will be higher than that of other reviewed claims. The CMS will continue to monitor and evaluate the effectiveness of this demonstration, as well as the savings to the Medicare Trust Fund.

Outpatient Therapy Reviews

Due to a steady increase in therapy spending over the past few years, President Obama signed into law the American Taxpayer Relief Act (ATRA) of 2012, which extended the Medicare Part B Outpatient Therapy Cap Exceptions Process through December 31, 2013. Section 603 of this Act contains a number of Medicare provisions which directly impact the medical review threshold for outpatient therapy caps. Provisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 required CMS to temporarily apply therapy caps (and related provisions) to the therapy services furnished in an outpatient hospital between the dates January 1, 2013 through December 31, 2013[11].

Claims for therapy services that have exceeded the threshold cap for the year require complex medical review. There are two separate thresholds that trigger the medical review process:

- A $3,700 cap for Occupational Therapy (OT) services per year, per beneficiary.
- A $3,700 combined cap for Physical Therapy (PT) and Speech Language Pathology (SLP) services per year, per beneficiary. Note: Although PT and SLP services are combined for triggering the threshold, medical review is conducted separately by discipline.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Private Practices
- Part B Skilled Nursing Facilities
- Home Health Agencies (TOB 34X)
- Outpatient Rehabilitation Facilities (ORFs)
- Rehabilitation Agencies (Comprehensive Outpatient Rehabilitation Facilities)
- Outpatient Hospitals

In states involved in the prepayment review demonstration, applicable therapy claims above the cap are flagged for review before payment. In the remaining states, these claims are paid upon claim submission, and then held for immediate Recovery Auditor postpayment review. In most circumstances, the Recovery Auditors reviewed these claims within 10 business days.

[11] The Pathway for Sustainable Growth Rate (SGR) Reform Act of 2013 extended these reviews through March 31, 2014.

Corrective Actions

The CMS continues to improve its process of developing corrective actions to prevent improper payments. The development of corrective actions is an agency-wide collaborative effort.

The CMS has established a process to implement corrective actions on program vulnerabilities based on Recovery Auditor reviews. Recovery Auditors request approval from CMS to review different types of claims. The request can be based on a particular code or group of codes, a particular setting, or any number of factors. These approved review areas are referred to as "issues." Recovery Auditors post these issues to their individual websites. In FY 2013, if the same issue was approved for each of the four Recovery Audit regions, CMS considers those four separate issues one issue.

Definition and Identification of Vulnerabilities

The causes of improper payments for issues are often similar and can be addressed with similar corrective actions. The CMS analyzes all issues with more than $500,000 in Recovery Audit corrections and groups them into vulnerability categories. A vulnerability is defined as a claim type (or series of related claim types) that pose a financial risk to the Medicare FFS program due to its susceptibility to improper payments. Improper payments could be due to a lack of medical necessity, incorrect coding, or lack of documentation.

The CMS develops national claims processing system edits to prevent future improper payments. These edits can deny a claim or send an electronic message to the MACs to manually review a claim. Providers have the right to appeal a claim that is denied by national claims processing system edits. The MACs develop edits for their local claim processing systems based on identified improper payments in their jurisdiction. Additionally, CMS develops medically unlikely edits that deny claims where the services billed exceed a number that would be clinically reasonable. The CMS develops National Correct Coding Initiative (NCCI) edits to catch those services that are coded incorrectly. Both medically unlikely edits (MUEs) and NCCI edits are updated quarterly.

Vulnerabilities identified through automated review may be corrected by national claims processing system edits, MUE or NCCI edits. However, those identified through complex review generally cannot be corrected by an edit. They may need to be corrected through provider education, prepayment review, postpayment review, or changes in CMS policy. Semi-automated review vulnerabilities are included in the complex category since they cannot be corrected by an edit. (Refer to page 4 for the definitions of automated, semi-automated, and complex reviews.)

Summary of FY 2013 Vulnerabilities[12]

The CMS prioritizes vulnerabilities based on the dollar amount corrected, as well as the date the vulnerability was identified. In FY 2013, CMS identified 25 vulnerabilities through the Recovery Audit

[12] Senate Committee Report 112-176 requested the inclusion of Recovery Auditor identified vulnerabilities in the annual Medicare FFS Recovery Audit Report to Congress. (U.S. Senate. Committee on Appropriations. *Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2013, (to Accompany S. 3295)* (112 S. Rpt. 176)*)*

program. Twenty-one of the 25 vulnerabilities were identified through automated review. Four vulnerabilities were identified through complex review. As of September 30, 2013, the Recovery Auditors corrected $3.75 billion in improper payments based on these vulnerabilities.

Corrective Actions for Automated Vulnerabilities

The CMS works to address Recovery Auditor identified vulnerabilities promptly to prevent future improper payments. However, some vulnerabilities identified in FY 2013 will not have claims processing edits implemented until after FY 2013. It is possible that claims processing edits are already in place for some vulnerabilities, but need to be re-evaluated for effectiveness. It is also possible that edits have been implemented more recently, but the effects of the edit have not yet been realized.

- The CMS implemented three national edits in FY 2013 for topics identified in FY 2012.
- The CMS drafted four national edits in FY 2013 that are scheduled to be implemented in FY 2014 for topics identified in FY 2012.
- The CMS implemented updates to MUE/NCCI edits quarterly in FY 2013.

Below are vulnerabilities that have been addressed but are awaiting implementation:

- The CMS is reviewing 19 automated vulnerabilities identified in FY 2013 for potential edits at the national level.
- The CMS drafted national edits in FY 2013 for 12 FY 2012 automated vulnerabilities that have a potential implementation date in FY 2014 or later.

National system edits are based on NCDs. Recovery Auditor automated vulnerabilities based on NCDs are eligible for national system edits. Recovery Auditor automated vulnerabilities based on MAC LCDs require local system edits. These policies are individualized and can differ among each MACs. Although the MACs receive regular notification of all Recovery Auditor vulnerabilities, they have limited resources with which to implement their edits. Through their Medical Review Strategy (MRS) report, their ERRP, and data analysis, MACs prioritize the areas most susceptible to improper payments in their jurisdiction. They then focus on those areas that would benefit most from local system edits. The CMS does not instruct the MACs on which system edits to implement.

Corrective Actions for Complex Vulnerabilities

Below is a summary of actions that have been taken:

- The CMS Rule 1599-F (effective October 1, 2013) allows Medicare to pay for reasonable and necessary Part B hospital inpatient services when a Part A inpatient admission is denied as not reasonable and necessary. This policy also permits the hospital to bill for Part B hospital inpatient services if the hospital conducts a self-audit or other utilization review which suggests that the beneficiary should have been treated as an outpatient, rather than admitted to the hospital as an inpatient. This rule also expanded payment for Part B hospital inpatient services, which was previously limited to a subset of services known as ancillary services. The final rule confirmed that claims must be submitted within 12 months of the date of service to receive payment.

- The CMS Rule 1599-F, as proposed through CMS Rule 1455-P, was released at the same time as CMS Administrator's Ruling 1455-R. Ruling 1455-R provided an interim process for issuing Part B inpatient hospital payments during the proposed rulemaking. This ruling was instituted to address the significant number of pending appeals of Part A hospital inpatient reasonable and necessary denials. It also established a standard process to allow billing for the additional Part B

inpatient payment. For claims that fell within the timeframes listed in 1455-R, timely filing was waived. This ruling did not permit Part B inpatient hospital payments for post-discharge self-audit determinations. Ruling 1455-R was effective until CMS Rule 1599-F was implemented on October 1, 2013.

- The CMS initiated a 3-year Prior Authorization of Power Mobility Devices (PMDs) Demonstration on September 2012. Based on data initially collected, spending per month on power mobility devices in the seven demonstration states decreased after September 2012, as did spending per month on power mobility devices in the non-demonstration states. Specifically, monthly expenditures for power mobility devices in the demonstration states decreased from $20 million in September 2012 to $9 million in August 2013, and from $12 million to $4 million in the non-demonstration states for the same time period. The CMS believes many national suppliers have adjusted their billing practices nationwide and are now complying with CMS policies based on their experiences with prior authorization in the demonstration states.

- The CMS developed data elements for an Electronic Clinical Template for PMDs. For more information, please visit the website at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/ESMD/ElectronicClinicalTemplate.html.

- The CERT program has completed nine Special Studies in FY 2013. CERT Special Study topics are available to providers. MACs post the topics under review on their websites. Special Studies are intended to provide information on areas which:
    - Have had historically high improper payment rates
    - Are at risk for improper payments
    - Are new Medicare covered benefits
    - Have recently been impacted by changes in policy

- The CMS has issued 11 reports on FFS facility billing practices in FY 2013. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a file containing hospital-specific data statistics for target areas often associated with Medicare improper payments due to billing, MS-DRG coding and/or admission necessity issues. Target areas are determined by CMS.

  PEPPERs can be used to compare data statistics over time to identify changes in billing practices, pinpoint areas in need of auditing and monitoring, identify potential DRG under- or over-coding problems and identify target areas where length of stay is increasing. PEPPERs can assist hospitals and facilities achieve CMS's goal of reducing and preventing improper payments. For more information, please visit the PEPPER website at: http://www.pepperresources.org/Data.aspx.

- The CMS has issued 36,000 reports on billing practices for eight facility types in FY 2013. Comparative Billing Reports (CBRs) contain data-driven tables and graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers located in their state and across the nation.

  To ensure privacy, CMS ensures that each agency CBR is provided confidentially and provides only summary billing information. No patient or case-specific data is included. CMS believes CBRs are a tool to help providers better understand Medicare billing rules and improve the level of care for patients. The MACs post CBR topics under the review section of their websites.

- The CMS has issued 17 Medicare Learning Network (MLN) articles and 4 Quarterly Provider Compliance Newsletters in FY 2013. The CMS has received positive feedback from provider associations regarding the value of these documents, and plans to continue their issuance. For more information, these articles are available at: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html.

  The CMS contractors also post MLN Matters articles to their websites as well as other educational material relevant to CMS policy and LCDs for their jurisdictions. For more information, please review national policy guidance at: http://www.cms.gov/medicare-coverage-database.

Continuous Improvement

The CMS is committed to working with the Recovery Auditors, the provider and supplier communities, and other stakeholders to continuously improve the program and refine ongoing operations.

Recovery Auditors continue to participate and encourage providers to participate in the esMD program, which facilitates the paperless transmission of electronic medical records. All four Recovery Auditors saw participation in the esMD program increase in FY 2013, with an average participation increase of ten percent. Provider participation varies across Recovery Auditors, but is as high as 20 percent of all documentation submitted to Performant, the Recovery Auditor in Region A.[13] This esMD program promotes both efficiency and organization, while reducing provider burden and administrative costs. The CMS anticipates even higher participation in FY 2014.

The CMS encourages the Recovery Auditors and claims processing contractors to meet to discuss program issues and potential improvements. The CMS hosts regular teleconference meetings that serve as a forum to focus on clinical issues, appeals, operational issues, and best practices. By nurturing contractor collaboration, CMS hopes to:

- Ensure uniform policy application;
- Limit inaccurate identifications by the Recovery Auditors based on different interpretations of the policy;
- Limit unnecessary appeals to reduce provider burden and costs; and
- Ensure review topics are not being reviewed by more than one Medicare fee-for-service entity to further reduce provider and supplier burden.

The CMS continues to encourage Recovery Auditors to expand their review strategies to include different types of providers, including a statement of work (SOW) change that emphasizes the review of claim types with high error rates. In FY 2013, HDI, the Region D Recovery Auditor, began reviewing SNF claims for spans of care. This includes reviewing all claims billed from the date of admission through discharge, for a single beneficiary. This type of review can average between one and five claims per span of care. Additionally, Recovery Auditors continue to expand their reviews on hospice, home health, and inpatient rehabilitation facility providers.

At times, CMS will refer issues of potential improper payments to the Recovery Auditors for their review. These referrals may come from MACs and ZPICs, or external entities such as the Office of Inspector General (OIG) and Government Accountability Office (GAO). These referrals will typically include uniform review rationale and website language, as well as standard claim selection criteria and edit parameters to ensure that all Recovery Auditors are reviewing the claims consistently. These referrals are optional for the Recovery Auditors, and should a Recovery Auditor choose not to accept a particular issue, CMS retains the right to give those claims to a different Recovery Auditors for review. Recovery

[13] This data is self-reported by the Recovery Auditors.

Auditors do receive an increased contingency fee on those reviews that results in improper payment correction.

In FY 2013, CMS referred the following issues to the Recovery Auditors for review:

- MS – DRG 004 Tracheostomy with Mechanical Ventilation 96+ hours
- Trastuzumab (Herceptin), Multi-use vial waste
- Cancelled Elective Surgeries
- Blepharoplasty (Eyelid/Eyebrow lifts and repairs)
- Intensity Modulated Radiation Therapy
- Maximum Allowed Units for Part B Drugs and Biologicals
- Beneficiaries Receiving Diabetic Supplies above the Maximum Allowance

All Recovery Auditors chose to review all of the above referrals. Some Recovery Auditors initiated their own reviews for some of the issues, outside of the CMS referral process.

The CMS regularly evaluates the Recovery Auditors' performance and adherence to the requirements in their SOWs. Staff members go on location to observe medical reviewers, Information Technology systems, and customer service areas. When onsite visits are not possible, CMS conducts desk audits on claims to confirm that all aspects of the review process were completed correctly and accounted for in the Data Warehouse. Regular meetings with claims processing contractors, provider groups, and other stakeholders are also monitored for additional contractor oversight. If there are any findings in these evaluations, CMS notifies the Recovery Auditor and requires a corrective action plan. The results of these regular evaluations are consolidated annually in the Contractor Performance Assessment Rating System (CPARS) for an overall performance rating for the year. These results are available to all federal agencies. The CMS believes that regular contractor oversight is essential to the success of the Recovery Audit Program.

Program Development

As part of CMS's comprehensive plan to reduce the improper payment rate, CMS is exploring several options to improve the Recovery Audit Program. As discussed earlier in the report, in FY 2012, CMS implemented a demonstration that allowed participating hospitals to rebill for services related to inpatient short-stay claims that were denied on the basis that the inpatient stay was not medically necessary. This demonstration was terminated on March 13, 2013, after CMS issued interim Ruling 1455–R (78 FR 16614) on March 13, 2013, which established a standard process for handling pending appeals and billing for the additional Part B inpatient services while the proposed new policy went through notice and comment rulemaking. Rule 1455-P was finalized in Rule 1599-F (78 FR 50495, August 2, 2013) and permits inpatient Part B payment following the denial of a Part A inpatient admission as not reasonable and necessary. The provisions of 1599-F apply to claims that were subject to CMS Ruling 1455-R and claims with dates of admission on or after October 1, 2013. For these categories of claims, the timeframe for submitting Part B inpatient claims that was adopted in CMS Ruling 1455-R continues to apply.

OIG Oversight

In September 2013, the OIG issued a report on Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance, OEI-04-11-00680. The report focused on the extent the FFS Recovery Auditors identified improper payments and the corrective actions CMS took to address those payment vulnerabilities. The OIG also examined the extent to which the Recovery Auditors referred suspected fraud to CMS and the actions CMS took on those referrals. Finally, OIG reviewed the extent that the Recovery Auditors' performance evaluations addressed performance metrics and contract requirements.

The OIG found that CMS took action to address the majority of vulnerabilities identified but did not assess the effectiveness of these actions. The OIG also found that CMS did not take action to address six referrals of potential fraud. Lastly, the OIG reported that CMS's performance evaluations did not include metrics to evaluate the contractors on all contract requirements.

Specifically, the OIG recommended that CMS take action on vulnerabilities that are pending corrective action and determine the effectiveness of implemented corrective actions. CMS concurred with this recommendation and considers the vulnerabilities that were pending action at the time of OIG's audit to be closed. The CMS agrees that determining the effectiveness of corrective actions is important and will explore the feasibility of developing a protocol that attempts to quantify the effectiveness of corrective actions using a combination of tools including data analysis, error rate measurement, continued identification of overpayments via post payment review, and other factors.

The OIG also recommended that CMS increase the Recovery Auditors' referral of potential fraud. The CMS agreed and will facilitate increased collaboration between Recovery Auditors, CMS and program integrity contractors. Per the Office of Financial Management's (OFM) Memorandum of Understanding (MOU) with the OIG, CMS will ensure that the Recovery Auditors continue to concurrently refer all instances of suspected fraud both to the OIG and to CMS. The OIG recommended that CMS take action on the six instances of suspected fraud that the Recovery Auditors referred to CMS. The CMS did review

these in concert with the applicable ZPIC/Program Safeguard Contractor (PSC). One referral resulted in revoking Medicare billing privileges from that provider.

In addition, the OIG recommended that CMS develop additional performance evaluation metrics to improve Recovery Auditor performance and ensure that they are evaluated on contract requirements. The CMS concurred that performance metrics such as accuracy and appeal targets are important measures and should be a part of the regular performance evaluations. The CMS revised the latest Contractor Performance Assessment Reporting System (CPARS) evaluations to incorporate metrics on the Recovery Auditors' identification of improper payments and accuracy rates. The CMS does not believe it is appropriate to include other metrics such as quotas for fraud referrals, as that is not a major task of these contracts. The CMS also revised the next SOW to add a metric based on the number of overpayment determinations overturned at the first level of appeal, as well as other relevant performance measures.

GAO Oversight

On July 23, 2013, the GAO issued "Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency" (GAO 13-522). This report states that postpayment review contractors such as Recovery Auditors, as well as MACs, ZPICs, and the CERT review contractor differ in requirements for claims reviews and assessed the extent to which requirements for postpayment claims reviews differ across the contractors and whether differences, if any, could impede effective and efficient claims reviews.

The GAO recommended that CMS examine all postpayment review requirements for contractors to determine those that could be made more consistent without negative effects on program integrity; communicate publicly CMS's findings and its time frame for taking further action; and reduce differences in postpayment review requirements where it can be done without impeding the efficiency of its efforts to reduce improper payments. The GAO specifically noted that CMS asserts more controls over the Recovery Auditors than other contractor types, such as with ADR limits, the review approval process, posting review issues on websites, reimbursing certain providers for medical records, and offering a discussion period. The CMS agreed with the GAO's recommendations and is working toward more contractor consistency.

The CMS has started taking steps toward more contractor consistency. In the future Recovery Auditor SOW, CMS has removed the prohibition for the Recovery Auditors to deny claims for minor omissions (such as an illegible signature). The CMS has also reduced the number of days the Recovery Auditor has to review the documentation submitted by providers to 30 days. Additional changes are discussed in the Procurement section below.

Procurement and Contract Modification

In February 2013, CMS issued a Request for Quote (RFQ) through the General Services Administration (GSA) for the new Recovery Audit Program contracts. The CMS plans to contract with one nationwide Recovery Auditor to review all DME and Home Health and Hospice (HH/H) claims, and four Part A/B Recovery Auditors to review all other FFS Medicare claims. This change ensures that DME and HH/H claims are reviewed regularly, as they account for a high percentage of the error rate. The Part A/B Recovery Auditor regions were changed to more equally distribute the submitted claim volume, as well as to better align with the MAC jurisdictions.

Shortly after the release of the RFQ, CMS received a pre-award protest. The protester alleged that the transition plan CMS outlined would treat incumbent offerors differently than new offerors, with respect to the work on which they bid. The CMS began voluntary corrective action to mitigate the alleged differences and the GAO dismissed the protest.

During the corrective action process, CMS modified the Recovery Auditor contracts to include an additional 2- year period for payment reconciliation purposes. Because the full appeals process can take several years to complete, CMS needed a way to collect contingency fees for claims that are overturned on appeals after the current contracts are scheduled to end. During this extension period, Recovery Auditors will not be able to review claims for improper payment during this time. They will continue to receive collections for improper payment determinations made during the active recovery auditing period, as well as refund contingency fee payments for claims overturned on appeal. The CMS believes this contract extension best protects the Agency's interest in ensuring that Recovery Auditors only receive payment for those determinations that are upheld throughout the appeals process.

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Appendix A:

Social Security Act

SEC. 1893 MEDICARE INTEGRITY PROGRAM

(h)[393] 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 this title. 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 this title.

(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 (not later than December 31, 2010, in the case of contracts relating to payments made under part C or D).

(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 this title—

(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 a 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.

(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.

Appendix B: Amount Returned to the Medicare Trust Funds (in Millions)

Overpay-ments Collected	-	Underpay-ments Restored	-	Amount Over-turned on Appeal[14]	-	Recovery Auditor Contin-gency Fees	-	CMS Admini-stration Costs	=	Amount Returned to Medicare Trust Funds
$3,650.9		$102.4		$57.6		$301.7		$152.4		**$3,036.8**

Note: CMS administration costs include adjusting claims, hearing appeals, supporting contractors, and CMS full time equivalents.

[14] This includes only those appeals overturned at the first level.

Appendix C: FY 2013 Correctons by State

Corrections by State			
State	Overpayments Collected	Underpayments Restored	Total Corrected
AK	$9,207,253	$161,414	$9,368,667
AL	$67,806,360	$4,204,098	$72,010,458
AR	$32,485,533	$901,379	$33,386,913
AS	$7,490	-	$7,490
AZ	$85,798,901	$1,820,312	$87,619,212
CA	$516,927,724	$18,467,227	$535,394,951
CO	$34,952,746	$1,170,365	$36,123,111
CT	$58,434,434	$453,155	$58,887,589
DC	$11,720,454	$282,763	$12,003,217
DE	$18,041,433	$290,672	$18,332,105
FL	$239,144,006	$10,040,772	$249,184,778
GA	$74,888,969	$5,452,959	$80,341,928
GU	$94,513	$345	$94,858
HI	$12,444,457	$180,905	$12,625,362
IA	$59,212,667	$509,628	$59,722,295
ID	$7,634,618	$547,778	$8,182,395
IL	$113,612,641	$644,904	$114,257,546
IN	$66,132,778	$338,414	$66,471,192
KS	$48,752,733	$427,782	$49,180,514
KY	$52,268,088	$189,159	$52,457,248
LA	$50,191,533	$1,900,289	$52,091,822
MA	$64,535,086	$2,288,892	$66,823,978
MD	$22,836,315	$590,600	$23,426,915
ME	$16,815,831	$1,346,768	$18,162,599
MI	$108,477,545	$583,970	$109,061,515

Corrections by State			
State	Overpayments Collected	Underpayments Restored	Total Corrected
MN	$42,275,769	$2,187,472	$44,463,240
MO	$170,323,598	$1,957,621	$172,281,219
MP	$196	-	$196
MS	$38,846,506	$1,016,180	$39,862,685
MT	$23,725,229	$281,560	$24,006,789
NC	$147,174,259	$3,314,043	$150,488,302
ND	$23,283,527	$197,516	$23,481,043
NE	$21,133,441	$375,239	$21,508,680
NH	$9,368,686	$1,268,435	$10,637,121
NJ	$87,021,238	$1,082,276	$88,103,513
NM	$18,262,097	$635,753	$18,897,850
NV	$31,124,329	$742,263	$31,866,592
NY	$309,007,901	$3,250,242	$312,258,143
OH	$105,069,714	$234,960	$105,304,674
OK	$38,667,996	$1,092,908	$39,760,904
OR	$22,797,704	$1,422,113	$24,219,817
PA	$153,377,010	$1,971,860	$155,348,870
PR	$470,309	$71,872	$542,180
RI	$8,110,684	$428,385	$8,539,070
SC	$64,292,715	$1,532,476	$65,825,191
SD	$26,421,010	$163,235	$26,584,246
TN	$90,413,721	$3,356,658	$93,770,379
TX	$152,104,032	$6,504,474	$158,608,506
UT	$24,256,186	$453,839	$24,710,026
VA	$100,055,017	$3,168,014	$103,223,031

Corrections by State			
State	**Overpayments Collected**	**Underpayments Restored**	**Total Corrected**
VI	$585,498	$111	$585,609
VT	$4,798,836	$390,953	$5,189,789
WA	$49,909,476	$2,668,186	$52,577,662
WI	$39,881,495	$2,996,092	$42,877,587
WV	$37,337,739	$1,118,670	$38,456,409
WY	$10,620,664	$67,408	$10,688,072
Unknown[15]	$27,773,935	$5,663,139	$33,437,075
Total	***$3,650,914,625***	***$102,408,504***	***$3,753,323,129***

[15] These claims could not be attributed to a specific state.

Appendix D1: FY 2013 Corrections by Type of Claim

Corrections by Claim Type						
	Overpayments Collected		Underpayments Restored		Total Corrected	
Claim Type	No. of claims	Amount Collected	No. of Claims	Amounted Restored	No. of Claims	Amount Corrected
Part A	724,757	$3,518,928,568	32,331	$100,723,074	757,088	$3,619,651,642
Part B	443,248	$58,021,835	10,213	$1,459,676	453,461	$59,481,511
DME	321,633	$73,964,222	67	$225,754	321,700	$74,189,976
Total	***1,489,638***	**$3,650,914,625**	***42,611***	**$102,408,504**	***1,532,249***	**$3,753,323,129**

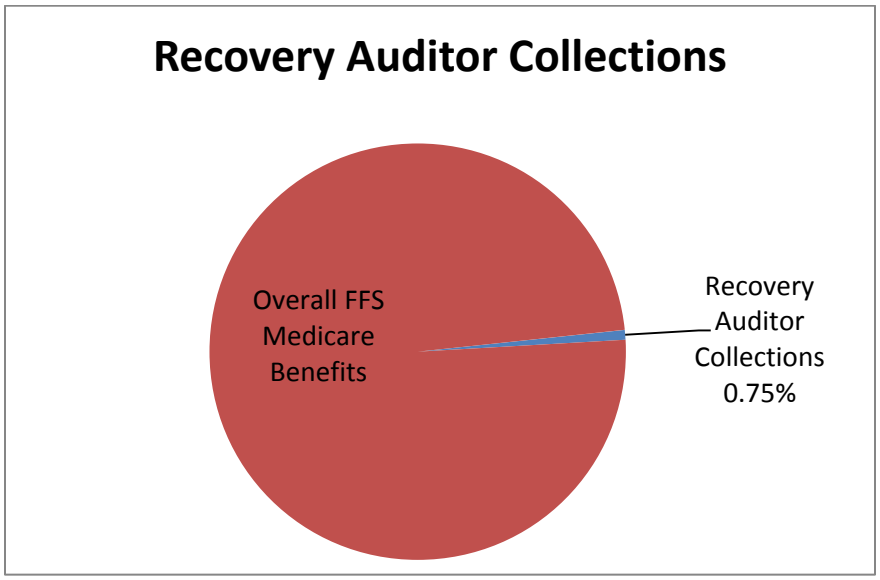
Appendix D2: FY 2013 Overall FFS Medicare Benefits (in Billions)

Benefit Type	Expenditures
Part A	255.2
Part B	225.9
Total	***481.1***

Note: Total excludes Managed Care and Part D expenditures.

Source: CMS Office of the Actuary

Appendix D3: FY2013 Recovery Auditor Collections as Compared to Total FFS Medicare Benefits



Appendix E: FY 2013 Corrections by Recovery Auditor and Type of Claim

Corrections by Recovery Auditor and Type of Claim							
		Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	Claim Type	No. of Claims	Amount Collected	No. of Claims	Amount Restored	No. of Claims	Amount Corrected
Performant	A	129,914	$728,789,768	3,692	$14,478,741	133,606	$743,268,509
	B	34,782	$5,396,771	65	$3,727	34,847	$5,400,498
	DME	200,739	$28,125,575	66	$225,754	200,805	$28,351,329
	Subtotal	*365,435*	$762,312,114	*3,823*	$14,708,223	*369,258*	$777,020,336
CGI	A	108,172	$525,010,402	2,257	$7,762,716	110,429	$532,773,118
	B	18,928	$3,008,795	159	$18,878	19,087	$3,027,673
	DME	5,687	$712,300	-	-	5,687	$712,300
	Subtotal	*132,787*	$528,731,497	*2,416*	$7,781,593	*135,203*	$536,513,091
Connolly	A	267,443	$1,158,022,927	17,072	$47,126,346	284,515	$1,205,149,273
	B	203,032	$27,991,605	6,130	$1,232,408	209,162	$29,224,013
	DME	67,215	$33,034,979	1	-	67,216	$33,034,979
	Subtotal	*537,690*	$1,219,049,512	*23,203*	$48,358,754	*560,893*	$1,267,408,266
HDI	A	219,141	$1,106,951,805	9,308	$31,316,966	228,449	$1,138,268,771
	B	186,489	$21,623,113	3,859	$204,662	190,348	$21,827,775
	DME	47,992	$12,091,367	-	-	47,992	$12,091,367
	Subtotal	*453,622*	$1,140,666,285	*13,167*	$31,521,627	*466,789*	$1,172,187,913
Unknown	A	87	$153,665	2	$38,307	89	$191,972
	B	17	$1,552	-	-	17	$1,552
	Subtotal	*104*	$155,217	*2*	$38,307	*106*	$193,524
Total		***1,489,638***	***$3,650,914,625***	***42,611***	***$102,408,504***	***1,532,249***	***$3,753,323,129***

Appendix F1: FY 2013 Corrections by Provider Type

Corrections by Provider Type			
Claim Type	**Overpayments Collected**	**Underpayments Restored**	**Total Amount Corrected**
Inpatient	$3,437,554,670	$86,149,338	$3,523,704,008
SNF	$1,840,735	$19,567	$1,860,302
Hospice	$34,858	-	$34,858
Outpatient	$46,637,617	$5,071,482	$51,709,099
Home Health	$6,386,724	$4,037,775	$10,424,498
Physician	$56,836,203	$1,241,449	$58,077,652
DME	$73,849,883	$225,754	$74,075,638
Unknown	$27,773,935	$5,663,139	$33,437,075
Total	***$3,650,914,625***	***$102,408,504***	***$3,753,323,129***

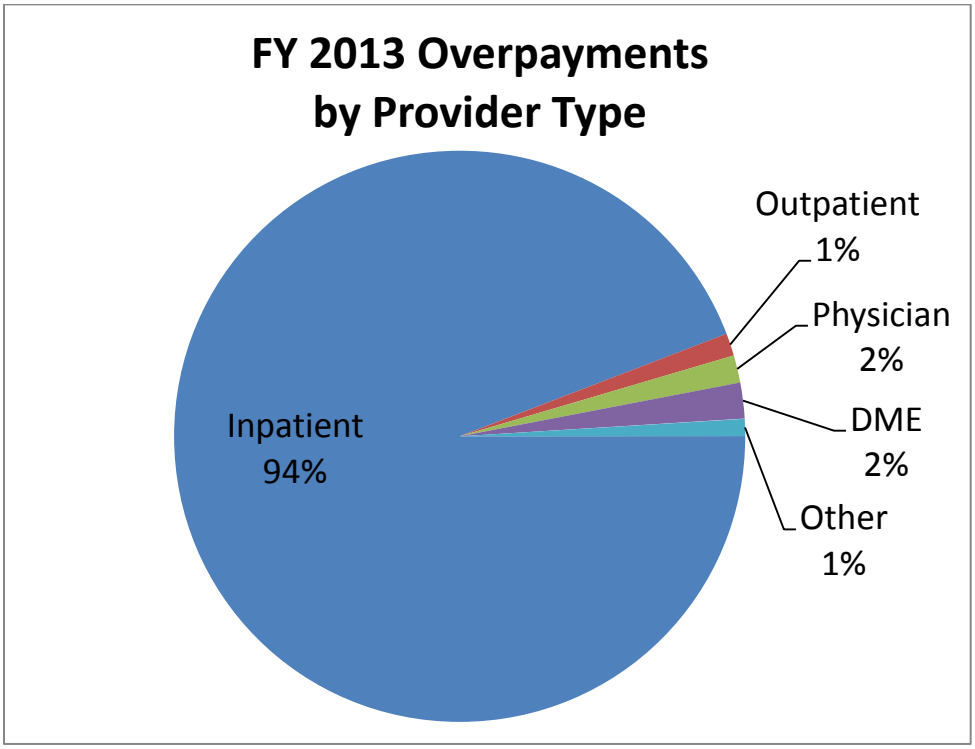
Appendix F2: FY 2013 Total Medicare Benefit Payments by Provider Type

Claim Type	Total Benefit Payments (in millions)
Inpatient	139,404
SNF	28,853
Hospice	15,642
Outpatient	36,379
Home Health	19,005
Physician/other suppliers	71,301
DME	8,343
Other Carrier	20,823
Other Intermediary	17,256
Laboratory	9,998
Total	***367,003***

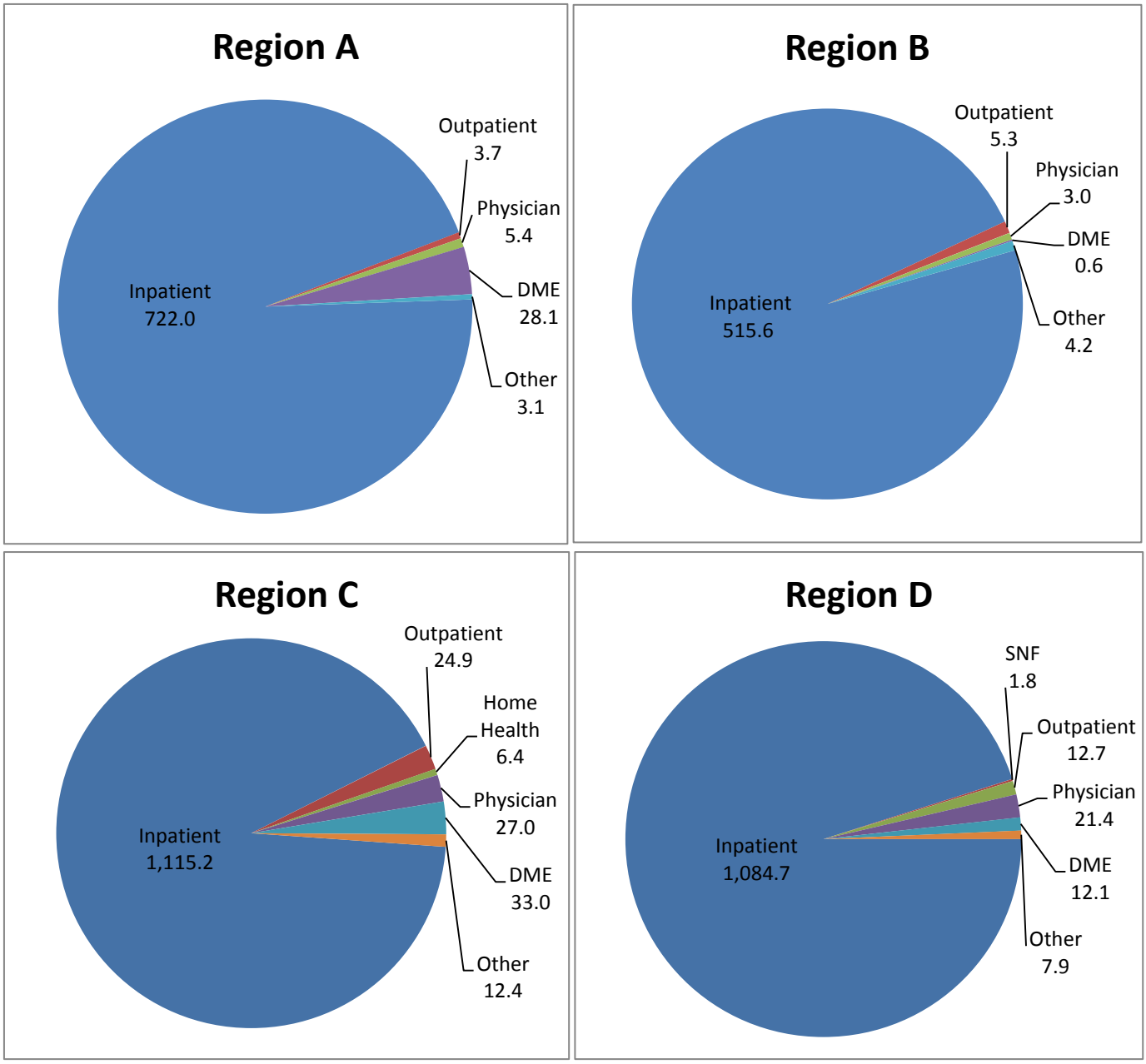
Note: Total excludes Managed Care and Part D expenditures.

Source: CMS, Office of the Actuary

Appendix G1: FY 2013 Overpayments by Provider Type



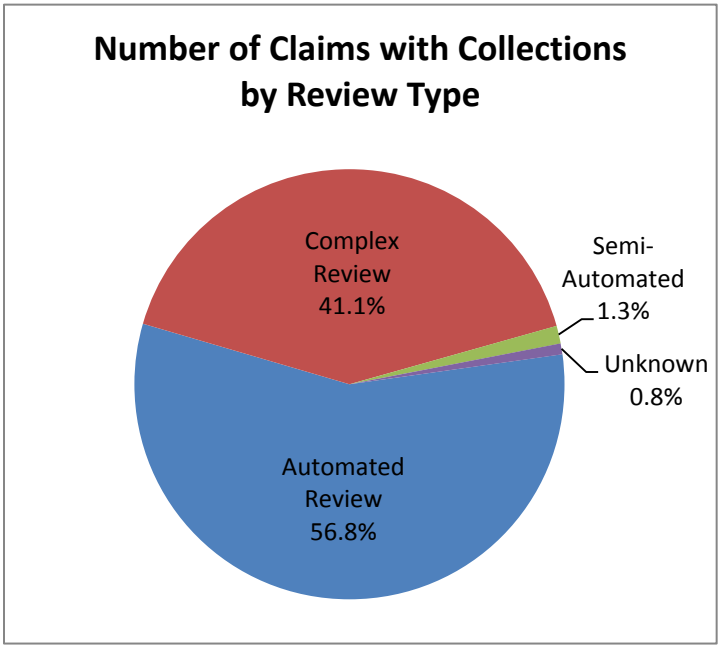
Appendix G2: FY 2013 Overpayments by Provider Type and Recovery Auditor (in millions)

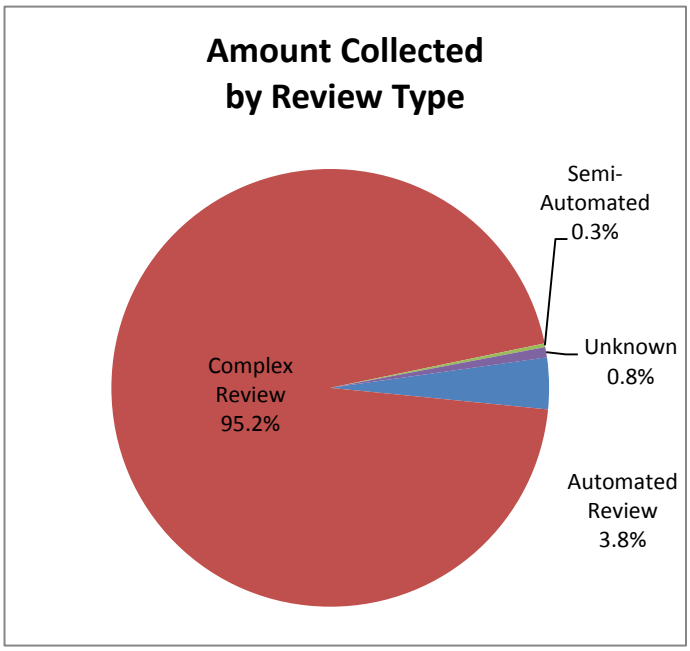


Appendix H1: FY 2013 Corrections by Review Type

Corrections by Review Type						
	Overpayments Collected		Underpayments Restored		Total Corrected	
Review Type	No. of Claims	Amount Collected	No. of Claims	Amount Restored	No. of Claims	Amount Corrected
Automated	845,483	$139,039,591	22,504	$39,355,705	867,987	$178,395,296
Complex	612,066	$3,474,353,152	16,260	$57,359,637	628,326	$3,531,712,789
Semi-Automated	19,857	$9,747,947	39	$30,023	19,896	$9,777,969
Unknown[16]	12,232	$27,773,935	3,808	$5,663,139	16,040	$33,437,075
Total	***1,489,638***	***$3,650,914,625***	***42,611***	***$102,408,504***	***1,532,249***	***$3,753,323,129***

Appendix H2: FY 2013 Collections by Review Type





[16] These claims could not be attributed to a specific review type.

Appendix H3: FY 2013 Corrections by Review Type and Recovery Auditor

		Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	**Review Type**	**No. of Claims**	**Amount Collected**	**No. of Claims**	**Amount Restored**	**No. of Claims**	**Amount Corrected**
Perfor-mant	Auto	245,918	$31,796,193	149	$30,150	246,067	$31,826,493
	Complex	117,295	$726,257,980	3,416	$13,359,208	120,711	$739,620,604
	Semi-Auto	1,091	$1,148,355	14	$56	1,105	$1,148,425
	Unknown	1,131	$3,109,585	244	$1,318,808	1,375	$4,428,637
	Subtotal	*365,435*	*$762,312,114*	*3,823*	*$14,708,223*	*369,258*	*$777,024,159*
CGI	Auto	33,197	$6,427,344	252	$21,784	33,449	$6,449,380
	Complex	97,633	$517,818,356	1,768	$6,924,371	99,401	$524,744,495
	Semi-Auto	251	$312,877	4	$19,781	255	$332,662
	Unknown	1,706	$4,172,921	392	$815,657	2,098	$4,988,970
	Subtotal	*132,787*	*$528,731,497*	*2,416*	*$7,781,593*	*135,203*	*$536,515,507*
Connolly	Auto	300,773	$61,250,223	12,906	$15,988,663	313,679	$77,251,791
	Complex	225,908	$1,144,218,965	9,582	$30,469,695	235,490	$1,174,698,242
	Semi-Auto	4,622	$1,187,041	11	$628	4,633	$1,187,681
	Unknown	6,387	$12,393,283	704	$1,899,768	7,091	$14,293,755

	Subtotal	*537,690*	*$1,219,049,512*	*23,203*	*$48,358,754*	*560,893*	*$1,267,431,469*
HDI	Auto	265,595	$39,565,830	9,197	$23,315,108	274,792	$62,890,136
	Complex	171,230	$1,086,057,851	1,494	$6,606,363	172,724	$1,092,665,708
	Semi-Auto	13,893	$7,099,674	10	$9,557	13,903	$7,109,240
	Unknown	2,904	$7,942,930	2,466	$1,590,599	5,370	$9,535,995
	Subtotal	*453,622*	*$1,140,666,285*	*13,167*	*$31,521,627*	*466,789*	*$1,172,201,080*
Unknown [17]	Unknown	*104*	$155,217	*2*	$38,307	106	$193,526
Total		***1,489,638***	***$3,650,914,625***	***42,611***	***$102,408,504***	***1,532,249***	***$3,753,365,740***

[17] These claims could not be attributed to a specific Recovery Auditor or review type.

Appendix I: FY 2013 Complex Review Improper Payment Identification Rate

Recovery Auditor	Number of ADRs Fulfilled by Providers	Improper Payment Identifications*	Improper Payment Identification Rate
Performant	245,018	85,337	34.8%
CGI	213,153	68,525	32.1%
Connolly	525,900	219,543	41.7%
HDI	310,721	137,202	44.2%
Total/Average	***1,294,792***[18]	***510,607***	***39.4%***

*Identifications include claims with demanded overpayments and underpayments

[18] Providers must send in their medical documentation within 45 days of receiving an ADR from a Recovery Auditor. If the provider doesn't send in the appropriate documentation in this timeframe, the Recovery Auditor will deny the claim. This chart does not include those technical denials based on non-receipt of documentation.

Appendix J: FY 2013 Cumulative Accuracy Scores

Cumulative Accuracy Score	
Recovery Auditor	**Accuracy Score**
Performant	99.1%
CGI	96.8%
Connolly	92.8%
HDI	97.0%

Note: In FY 2013, 11 random samples from each Recovery Auditor were drawn to determine the accuracy scores. The universe for each region was all claims adjusted by the Recovery Auditor from May 2012 - July 2013. The sample size reviewed for each Recovery Auditor was between 799 and 1020 claims.

Appendix K1: FY 2013 Appeals by Claim Type – Level 1 (MAC)

Claim Type	Claims with Overpayment Determinations	Appealed Claims Decided	% of Overpayment Determinations Appealed	Decided Claims Overturned	
				#	%
Part A	811,646	388,387	47.9%	29,330	7.6%
Part B/DME	821,012	112,242	13.7%	69,398	61.8%
Total	1,632,658	500,629	30.7%	98,728	19.7%

Source: CMS CROWD System

Appendix K2: FY 2013 Appeals by Claim Type – Level 2 (QIC)

Claim Type	Appealed Claims Decided	Appealed Claims Withdrawn/ Dismissed		Decided Claims Overturned	
		#	%	#	%
Part A	293,739	6,614	2.3%	42,818	14.6%
Part B/DME	3,224	355	11.0%	580	18.0%
Total	296,963	6,969	2.3%	43,398	14.6%

Source: AdQIC (Q2A Administrators)

Appendix K3: FY 2013 Appeals by Claim Type – Level 3 (ALJ)

Claim Type	Appealed Claims Decided	Appealed Claims Withdrawn/ Dismissed		Appealed Claims Remanded to QIC		Decided Claims Overturned	
		#	%	#	%	#	%
Part A	37,795	5,758	15.2%	19,829	52.5%	9,372	24.8%
Part B/DME	937	40	4.3%	600	64.0%	134	14.3%
Total	38,732	5,798	15.0%	20,429	52.7%	9,506	24.5%

Source: OMHA

Appendix K4: FY 2013 Appeals by Claim Type – Level 4 (DAB)

Claim Type	Appealed Claims Decided	Appealed Claims Withdrawn/ Dismissed		Appealed Claims Remanded to ALJs		Decided Claims Overturned	
		#	%	#	%	#	%
Part A	495	189	38.2%	86	17.4%	13	6.0%
Part B/DME	30	8	26.7%	0	0.0%	0	0.0%
Total	525	197	37.5%	86	16.4%	13	5.5%

Source: AdQIC (Q2A Administrators)

Appendix K5: FY 2013 Total Appeal Decisions by Claim Type – All Levels

Claim Type	Total Appeal Decisions	Total Overturn Decisions[19]		% of Overpayment Determinations Overturned on Appeal
		#	%	
Part A	720,416	81,533	11.3%	10.0%
Part B/DME	116,433	70,112	60.2%	8.5%
Total	836,849	151,645	18.1%	9.3%

Note: The statistics above include first, second, third, and fourth level appeal decisions in FY 2013. Appealed claims may be counted multiple times if the claim had multiple appeal decisions rendered during FY 2013. For example, if a claim was appealed to the first level and received a decision in FY 2013, then appealed to the second level and received a decision in FY 2013, both decisions would be counted in the totals above. Claims may have overpayment determination dates prior to FY 2013.

[19] Includes overturn decisions at all levels of appeal during FY 2013.

Appendix L: Recovery Audit Program Informational Resources

Program Resources	
Website	**Information Provided**
go.cms.gov/RAC	This Recovery Audit Program specific agency website includes background information on the program, Recovery Auditor (and subcontractor) information for each region, the final Statement of Work, appeals information, limitations on recoupment, frequently asked questions, quarterly updates on corrections and identified vulnerabilities, and articles for provider education.
http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf	Contains archived provider compliance articles to help address common billing errors
Recovery Auditor Websites	Contains updated information on audits conducted, approved new issues, as well as sample correspondence and documentation submission instructions. The Recovery Auditor websites are as follows: 1)Region A/Performant Recovery: *performantrac.com* 2)Region B/CGI: *racb.cgi.com* 3)Region C/Connolly: *connolly.com/rac* 4)Region D/HDI: *healthdatainsights.com/rac*