Medicare Fee for Service
National Recovery Audit Program

(October 1, 2015 – December 31, 2015)

Quarterly Newsletter

*Figures rounded to nearest tenth; Nationwide figures rounded based on actual collections. Figures provided in millions. All correction data current through December 31, 2015.

	OVERPAYMENTS COLLECTED	UNDERPAYMENTS RETURNED	TOTAL QUARTER CORRECTIONS	FY TO DATE CORRECTIONS
Region A: Performant	$18.27	$6.40	$24.67	$24.67
Region B:CGI	$16.29	$1.58	$17.87	$17.87
Region C: Connolly	$53.90	$21.01	$74.91	$74.91
Region D: HDI	$43.84	$10.09	$53.93	$53.93
Nationwide Totals	**$132.30**	**$39.08**	**$171.38**	**$171.38**

TOP ISSUE PER REGION

*Based on collected amounts from October 1, 2015 through December 31, 2015

Region A:	**DMEPOS While Inpatient:** (automated review) A supplier may deliver a DMEPOS item to a patient in a hospital or nursing facility for the purpose of fitting or training the patient in the proper use of the item. This may be done up to two(2) days prior to the patient's anticipated discharge to their home. The supplier should bill the date of service on the claim as the date of discharge and shall use the place of service (POS) as 12 (patient's home). The item must be for subsequent use in the patient's home. No billing may be made for the item on those days the patient was receiving training or fitting in the hospital or nursing facility.
Region B:	**OP Rituximab 100mg Dose vs. Units Billed:** (complex review) Rituximab, (Rituxan), 100mg (J9310) should be billed one (1) unit for every 100mg per patient administered. Hospitals need to ensure that units of drugs administered to patients are accurately reported in terms of dosage specified in the full HCPCS code descriptor.
Region C:	**MMR of Therapy Claims Above $3,700 Threshold (OP):** (complex review) CMS determines an annual per beneficiary therapy cap amount for each calendar year. Exceptions to the therapy cap are allowed for reasonable and necessary therapy services. Per beneficiary, services above $3,700 for PT and SLP services combined and/or $3,700 for OT services are subject to manual medical review.
Region D:	**O.R. Procedures Unrelated to Principal Diagnosis MSDRGs 981– 989:** (complex review) MS-DRG Validation requires that diagnostic and procedural information and the discharge status of the beneficiary, as coded and reported by the hospital on its claim, matches both the attending physician description and the information contained in the beneficiary's medical record.