Medicare Fee for Service
National Recovery Audit Program

(January 1, 2015 – March 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 March 31, 2015.

| | OVERPAYMENTS COLLECTED | UNDERPAYMENTS RETURNED | TOTAL QUARTER CORRECTIONS | FY TO DATE CORRECTIONS |
|---|---|---|---|---|
| **Region A: Performant** | $17.28 | $3.16 | $20.44 | $38.25 |
| **Region B: CGI** | $2.14 | $2.11 | $4.25 | $8.60 |
| **Region C: Connolly** | $30.44 | $16.21 | $46.65 | $84.93 |
| **Region D: HDI** | $31.26 | $5.85 | $37.11 | $50.00 |
| **Nationwide Totals** | **$81.12** | **$27.33** | **$108.45** | **$181.78** |

## TOP ISSUE PER REGION

*Based on collected amounts through March 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 |
| **Region B:** | **OP Rituximab 100mg Dose vs. Units Billed - Post Pay:** (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:** | **Excessive or Insufficient Drug Units Billed - Outpatient:** (complex review) Drugs and Biologicals should be billed in multiples of the dosage specified in the HCPCS code long descriptor. The number of units billed should be assigned based on the dosage increment specified in that HCPCS long descriptor, and correspond to the actual amount of the drug administered to the patient, including any appropriate, discarded drug waste. If the drug dose used in the care of a patient is not a multiple of the HCPCS code dosage descriptor, the provider rounds to the next highest unit. Drug waste should be coded according to the requirements of the local contractor. Claims billed with excessive or insufficient units will be reviewed to determine the correct number of billable/payable units. |
| **Region D:** | **Skin and Connective Tissue Procedures:** (complex review) 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. |