Medicare Fee for Service
National Recovery Audit Program

(January 1, 2016 – March 31, 2016)

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, 2016.

	OVERPAYMENTS COLLECTED	UNDERPAYMENTS RETURNED	TOTAL QUARTER CORRECTIONS	FY TO DATE CORRECTIONS
Region A: Performant	$9.24	$3.52	$12.76	$37.43
Region B: CGI	$6.08	$1.42	$7.5	$25.37
Region C: Cotiviti	$43.21	$15.92	$59.13	$134.04
Region D: HDI	$67.54	$16.66	$84.2	$138.13
Nationwide Totals	**$126.07**	**$37.52**	**$163.59**	**$334.97**

TOP ISSUE PER REGION

*Based on collected amounts from January 1, 2016 through March 31, 2016

Region A:

Global Surgery: Pre- and Post-Operative Visits (automated review)

Identification of overpayments associated to minor and major surgical services. 1) E/M services (as specifically defined in the IOM) billed the day prior to a major (90-day) surgical service without modifiers 57 or 25. 2) E/M services (as specifically defined in the IOM) billed the day of a major (90-day) or minor (0- or 10-day) surgical service billed without modifier 25 or 57. 3) E/M services (as specifically defined in the IOM) billed 10 days following a 10-day minor surgical service or 90 days following a 90-day major surgical service and billed without modifier 24 (unrelated visit in post op period) or when modifiers 53, 54, 76, 78, Q0, and/or Q1 are appended to the surgical procedure.

Region B:

Outpatient Therapy Claims above $3,700 Threshold - Skilled Nursing Facility (complex review)

Targeted post-payment review of outpatient therapy claims paid in 2014 that reached the $3,700 threshold for PT and SLP services combined and/or $3,700 for OT services. When one or more lines of a claim have reached a therapy threshold, all lines of therapy services on that claim are subject to review.

Region C:

Outpatient Therapy Claims above $3,700 Threshold - Outpatient Hospital (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:

MS-DRG Validation of Major Diagnostic Category (MDC) 04 (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.

Reviewers will validate principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting MS-DRGs 163, 164, 165, 166, 167, 168,175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187,188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208