Medicare Fee for Service
National Recovery Audit Program

(April 1, 2016 – June 30, 2016)

Quarterly Newsletter

*Figures rounded to nearest tenth; Nationwide figures rounded based on actual collections.
Figures provided in millions. All correction data current through June 30, 2016.

	OVERPAYMENTS COLLECTED	UNDERPAYMENTS RETURNED	TOTAL QUARTER CORRECTIONS	FY TO DATE CORRECTIONS
Region A: Performant	$13.41	$3.45	$16.86	$54.30
Region B: CGI	$10.50	$1.12	$11.62	$37.00
Region C: Cotiviti	$23.04	$9.34	$32.37	$166.42
Region D: HDI	$28.28	$10.38	$38.66	$176.80
Nationwide Totals	**$75.22**	**$24.29**	**$99.52**	**$434.52**

TOP ISSUE PER REGION

*Based on collected amounts from April 1, 2016 through June 30, 2016

Region A:

(Issue # A000382009) (complex review)

MS-DRG Coding Validation: Severe Sepsis

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 for MS DRGs 177, 189, 193, 291, 438, 441, 444, 592, 602, 682, 689, 691, 693; principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the MS-DRG.

Region B:

(Issue # B001012013) (complex review)

Outpatient Therapy Claims above $3,700 Threshold - Skilled Nursing Facility

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:

(Issue # C002492013) (complex review)

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

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:

(Issue # D001712010) (complex review)

MS-DRG Coding Validation: Infections

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 for MSDRGs 094, 095, 096, 853, 854, 855, 867, 868, 869, principal diagnosis, secondary diagnosis, and procedures affecting or potentially affecting the DRGs. (At this time, Medical Necessity excluded from review)