Medicare Fee for Service
National Recovery Audit Program

(July 1, 2015 – September 30, 2015)

Quarterly Newsletter

*Figures rounded to nearest tenth; Nationwide figures rounded based on actual collections.
Figures provided in millions. All correction data current through September 30, 2015.

	OVERPAYMENTS COLLECTED	UNDERPAYMENTS RETURNED	TOTAL QUARTER CORRECTIONS	FY TO DATE CORRECTIONS
Region A: Performant	$26.63	$5.83	$32.46	$101.77
Region B:CGI	$20.72	$2.61	$23.33	$50.27
Region C: Connolly	$38.88	$16.30	$55.18	$198.02
Region D: HDI	$42.41	$11.47	$53.88	$123.94
Nationwide Totals	**$128.64**	**$36.21**	**$164.85**	**$474.00**

TOP ISSUE PER REGION

*Based on collected amounts from July 1, 2015 through September 30, 2015

Region A:	**MS-DRG Validation: Cardiac Valve Procedures:** (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.
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:	**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.
Region D:	**Gastrointestinal Procedures MSDRGs 326 - 358, 405 - 416, 417 - 425:** (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.