



Medicare Fee for Service  
National Recovery Audit Program  
(July 1, 2011– September 30, 2011)  
**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, 2011.

	OVERPAYMENTS COLLECTED	UNDERPAYMENTS RETURNED	TOTAL QUARTER CORRECTIONS	FY TO DATE CORRECTIONS (10/01/10-09/30/11)
Region A: DCS (Diversified Collection Services)	\$43.3	\$5.8	\$49.1	\$146.3
Region B: CGI (CGI Federal)	\$60.4	\$3.2	\$63.6	\$170.3
Region C: Connolly	\$65.2	\$60.7	\$125.9	\$260.9
Region D: HDI (HealthDataInsights)	\$108.2	\$6.9	\$115.1	\$361.8
<b>Nationwide Totals</b>	<b>\$277.1</b>	<b>\$76.6</b>	<b>\$353.7</b>	<b>\$939.4</b>

**TOP ISSUE PER REGION**

\*Based on collected amounts through September 30, 2011

<b>Region A:</b>	<b>Renal and Urinary Tract Disorders:</b> (Medical Necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with renal and urinary tract disorders needs to be complete and support all services provided.
<b>Region B:</b>	<b>Surgical Cardiovascular Procedures:</b> (Medical Necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients with surgical cardiovascular procedures needs to be complete and support all services provided.
<b>Region C:</b>	<b>Acute Inpatient Admission Neurological Disorders:</b> (Medical Necessity) Medicare pays for inpatient hospital services that are medically necessary for the setting billed. Medical documentation for patients admitted with neurological disorders needs to be complete and support all services provided.
<b>Region D:</b>	<b>Minor Surgery and other treatment billed as Inpatient :</b> (Medical Necessity) When beneficiaries with known diagnoses enter a hospital for a specific minor surgical procedure or other treatment that is expected to keep them in the hospital for less than 24 hours, they are considered outpatient for coverage purposes regardless of the hour they presented to the hospital, whether a bed was used, and whether they remained in the hospital after midnight.