Recovery Auditing in Medicare and Medicaid for Fiscal Year 2012

FY 2012 Report to Congress as Required by Section 1893(h) of the Social Security Act and Section 6411(c) of the Affordable Care Act

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Executive Summary

The missions of the Recovery Audit Programs are to identify and correct Medicare and Medicaid improper payments through the efficient detection and collection of overpayments made on claims of health care services provided to Medicare and Medicaid beneficiaries, and the identification of underpayments to providers so that the Centers for Medicare and Medicaid Services (CMS) can implement actions that will prevent future improper payments.

There are separate Medicare and Medicaid Recovery Audit Programs. The Medicare Fee for Service (FFS) Recovery Audit Program is authorized under Section 1893(h) of the Social Security Act (the Act). Section 6411(b) of the Affordable Care Act (ACA) expanded the use of Recovery Auditors, also known as Recovery Audit Contractors (RACs) to Medicare Parts C and D. The Medicare programs are administered by CMS.

Unlike the Medicare programs, Section 6411(a) of the ACA required the states to establish State Medicaid RAC programs. States individually procure, administer and operate their own programs, including determining the focus of audit issues that the State Medicaid RACs will review.

The Medicare FFS, Part C, Part D, and Medicaid Recovery Audit Programs each function independently. Details on each are provided throughout this report.

Medicare FFS Recovery Audit Program

The FFS program consists of a number of payment systems. It has a network of contractors that process more than one billion claims each year, submitted by more than one million healthcare providers, including hospitals, physicians, skilled nursing facilities (SNF), labs, ambulance companies, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers. These Medicare contractors, called Medicare Administrative Contractors (MACs), process claims, make payments to providers in accordance with Medicare regulations, and educate providers on how to submit accurately coded claims that meet Medicare guidelines.

The CMS uses several types of contractors to ensure that claims are paid based on Medicare guidelines. One type of contractor used is a Recovery Auditor, also known as a RAC. A Recovery Auditor's primary task is to review Medicare claims data and determine if a claim was appropriately paid. Section 1893(h) of the Act authorized the Recovery Audit Program expansion nationwide by January 2010. Prior to this, the Recovery Audit program operated as a demonstration in six states from March 2005 to March 2008. The national Recovery Audit Program was established in early 2009 after conducting a full and open competition. Four contracts were awarded for four distinct regions. Each Recovery Auditor is responsible for identifying overpayments and underpayments in a geographically defined area that is roughly one-quarter of the country. In addition, the Recovery Auditors are responsible for highlighting common billing errors, trends, and other Medicare payment issues to CMS.

In Fiscal Year (FY) 2012, Recovery Auditors collectively identified and corrected 1,272,297 claims for improper payments, which resulted in $2.4 billion dollars in improper payments being corrected. The total corrections identified include $2.3 billion in overpayments collected and $109.4 million in underpayments

repaid to providers and suppliers (see Appendix C). After taking into consideration all fees, costs, and first level appeals, the Medicare FFS Recovery Audit Program returned over $1.9 billion to the Medicare trust funds (Appendix B). These savings do not take into account program costs and administrative expenses incurred at the third and fourth levels of appeal (Office of Medicare Hearings and Appeals (OMHA) and Medicare Appeals Council within the Departmental Appeals Board (DAB), respectively), due to legislative restrictions which did not fund these administrative costs within the Recovery Audit Program. The CMS uses the results of audits performed by the Recovery Auditors to identify program vulnerabilities and take appropriate corrective actions to prevent future improper payments. The CMS hosts regular meetings with the Recovery Auditors, MACs, and CMS staff to discuss particular vulnerabilities and future corrective actions ranging from CMS educational articles, local and national system edits, and additional review by other entities. The CMS continues to make improvements to the Recovery Audit Program to help alleviate provider burden, ensure the accuracy of Recovery Auditor determinations, and promote transparency within the program. All Recovery Auditors have increased their use of the Electronic Submission of Medical Documentation (esMD) system to facilitate the transmission of medical documentation and help eliminate the costly and time-consuming need for providers to mail paper records for contractor review. The CMS is increasing collaboration between the Recovery Auditors and the MACs on many program elements such as data sharing and reporting, policy and coverage interpretation, appeals, and general operational issues and improvements. To aid in the appeal process, CMS has also been working with the Recovery Auditors to encourage further involvement in the appeals process, specifically at the Administrative Law Judge (ALJ) level of appeal. Involvement by Recovery Auditors in ALJ appeals aids in contractor and provider education, as it presents a forum for discussion, and can identify erroneous billing practices to the provider and policies that need clarification. The CMS continues to analyze the results of the Recovery Audit program to determine what corrective actions can be implemented to help reduce improper payments in the future.

In accordance with the President's initiative to eliminate waste and improper payments across Federal programs, the Medicare FFS Recovery Audit Program has proven to be a valuable tool to reduce improper payments.

Medicare Parts C and D RACs

Section 6411(b) of the Affordable Care Act (ACA) expanded the use of RACs to Medicare Parts C and D. The CMS has initiated implementation of Part C and Part D RAC programs. A contract for Part D recovery auditing was awarded on January 13, 2011. The Part D RAC's initial review focused on identifying improper payments for prescriptions written by excluded prescribers or filled by excluded pharmacies beginning with contract year 2007. Recoupment of approximately $2 million in overpayments began in the first quarter of FY 2013 for those plans identified in the Part D RAC's initial audit review. The Part D RAC is continuing its review of excluded providers and pharmacies for contract years 2008 and 2009. Notification of Improper Payment letters were sent to Part D plan sponsors during the 3rd quarter of FY 2013. In addition to the Part D RAC activity, CMS posted a Sources Sought Notice on April 4, 2013, seeking potential contractors to perform Part C RAC activities.

Medicaid RACs

State Medicaid agencies contract with Medicaid RACs to identify and recover overpayments and identify underpayments made to Medicaid providers. The CMS published a final rule implementing section 6411(a) of the Affordable Care Act in September 2011, and required states to implement Medicaid RAC programs by January 1, 2012.[1] During FY 2012, states requested and received approval for exceptions such as delays in the requirements of the final rule. For example, CMS approved states' requests to delay the required effective implementation date of January 1, 2012, extend the 3-year maximum claims look back period, and modify or exclude the requirement that their RAC vendors hire a full-time Contractor Medical Director.

As of September 30, 2012, 36 states had implemented Medicaid RAC programs, and CMS granted five U.S. territories complete exceptions from implementing RAC programs. Additionally, three states received time-limited exceptions from implementing Medicaid RAC programs. The CMS is working with the remaining 11 States and D.C. to implement their Medicaid RAC programs. In September 2012, CMS launched the Medicaid RACs-At-A-Glance (Phase II) website, which helps facilitate transparency and monitoring of the progress of Medicaid RAC programs. The updated website features state-reported information on each state's Medicaid RAC program, including contact information for each state Program Integrity Director, the name of each Medicaid RAC vendor and RAC Medical Director, contingency fee rates for the identification and recovery of overpayments and state profile pages. Additionally, CMS provided guidance and technical assistance to states through webinars and teleconferences during FY 2012 to help them implement their Medicaid RAC programs. For FY 2012, the states have recovered a total Federal and state share combined amount of $95.64 million and returned a total of $57.57 million to the Treasury through the state Medicaid programs. The majority of states are in the early stages of implementing audit operations. The CMS expects recoveries to increase as more states have fully operational State Medicaid RAC programs.

[1] The September 16, 2011 Medicaid RAC final rule is available online at http://www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf.

Introduction

Background

Faced with increasing national health expenditures and a growing beneficiary population, the importance and challenges of safeguarding the Medicare program are greater than ever.

The CMS uses a comprehensive strategy to prevent and reduce improper payments. Each year, CMS publishes a national improper payment rate for Medicare FFS, Part C, Part D, and Medicaid in accordance with the *Improper Payments Information Act of 2002 (IPIA)*, as amended by the Improper Payments Elimination and Recovery Act of 2010 and the Improper Payments Elimination and Recovery Improvement Act of 2012.[2]

As part of its efforts to implement the IPIA, CMS uses the Comprehensive Error Rate Testing (CERT) program to identify areas that may be vulnerable for improper payments in Medicare FFS. The CMS uses these results to direct future work by the Medicare FFS Recovery Audit program and the MACs.

In addition, each MAC is required to complete an Error Rate Reduction Plan (ERRP) that includes jurisdictional level strategies to reduce improper payments. These plans include the standard additional review and clarification of local and national policies as well as new and innovative ideas for reducing improper payments. These plans are targeted to potential claims that based on data analysis may be improper. Additional provider education, widespread or localized, is included, as well as clarifications and modifications to local coverage policies. These plans have proven to be successful in helping to reduce each MAC's error rate. Zone Program Integrity Contractors (ZPICs) provide additional protections for reducing improper payments by identifying and investigating areas of potential fraud, including those referred to them by MACs and Recovery Auditors. When warranted, ZPICs report providers and claims to law enforcement authorities who specialize in fraud, waste, and abuse prevention.

While several Medicare contractors are responsible for auditing Medicare claims, CMS has processes in place to ensure the work is collaborative and not duplicative. A claim that has been reviewed by one entity is not available to another entity for review, absent potential fraud. Any claim or provider currently being reviewed for potential fraud is usually not available for review by a Recovery Auditor and the contractors work together to ensure they all are not reviewing the same issues for the same providers. The CMS is continuously working to improve the collaboration between auditing contractors to ensure accurate and efficient auditing of Medicare claims while reducing provider burden and ensuring beneficiary access to health care/health services.

Improper Payments in the Medicare FFS Program

Claims submitted to Medicare are screened by thousands of system edits prior to payment; however, due to the large volume of claims submitted, most are generally paid without requesting and reviewing the

[2] Additional information about the Medicare Fee-for-Service national improper payment rate can be found at www.cms.gov/cert, and additional information on the Medicaid national improper payment rate can be found at www.cms.gov/perm.

supporting medical records to support the services billed. As a result, claims may be paid inappropriately, resulting in improper payments.

The most common reasons for improper payments are the following:

- Payment is made for services that do not meet Medicare's coverage and medical necessity criteria,
- Payment is made for services that are incorrectly coded, and
- Payment is made for services where the supporting documentation submitted does not support the ordered service.

Given the volume of claims submitted to Medicare on a daily basis, CMS is not able to perform 100 percent medical review on all claims prior to payment, commonly referred to as pre-payment review. The CMS must rely on conducting medical record review after payment, commonly referred to as post-payment review. The CMS and its contractors prioritize those claims which are most at risk for improper payment. These claims are then reviewed more thoroughly, as described in the Recovery Audit Review Process on page five.

Statutory Authority for Recovery Auditors

The Medicare FFS Recovery Audit Program began as a demonstration required in the Medicare Prescription Drug, Improvement and Modernization Act of 2003[3]. The demonstration was conducted from March 2005 to March 2008 in six states, to determine if Recovery Auditors could effectively be used to identify improper payments for claims paid under Medicare Part A and Part B. This demonstration allowed for additional review of Medicare claims for payment by utilizing Recovery Auditors on a contingency fee basis to identify and investigate claims with calculated risk. The Recovery Audit demonstration established Recovery Auditors as a successful tool in the identification and prevention of improper Medicare payments.

Section 1893(h) of the Act authorized the Recovery Audit Program expansion nationwide by January 2010 (see Appendix A1). This requires an annual Report to Congress including information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program. Section 6411(a) of the ACA required the states to establish State Medicaid RAC programs. States individually procure, administer, and operate their own programs, including determining the focus of audit issues that the State Medicaid RACs will review. States were required to establish State Medicaid RAC programs by submitting State plan amendments, which attest that their programs meet the statutory requirements, by December 31, 2010.

This report satisfies the requirement from Section 1893(h) of the Act, as well as the requirement in the ACA (P.L. 111-148) that requires an annual report to Congress concerning the effectiveness of the Recovery Audit Program under Medicaid and Medicare (Appendix A2).

[3] For more information on the Recovery Audit program demonstration see http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Recovery-Audit-Program/Downloads/RecoveryAuditDemonstration_vj508.pdf.

How Recovery Auditors are Paid

Recovery Auditors are paid on a contingency fee basis. The amount of the contingency fee is a percentage of the improper payment recovered from, or reimbursed to providers. The Recovery Auditors negotiate their contingency fees at the time of the contract award. The base contingency fees for Medicare FFS Recovery Auditors ranged from 9.0-12.5 percent for all claim types except DME. The contingency fees for DME claims ranged from 14.0 -17.5 percent. The Recovery Auditor must return the fee if an improper payment determination is overturned at any level of appeal.

Medicare FFS Recovery Auditor Review Process

The Use of Recovery Auditors

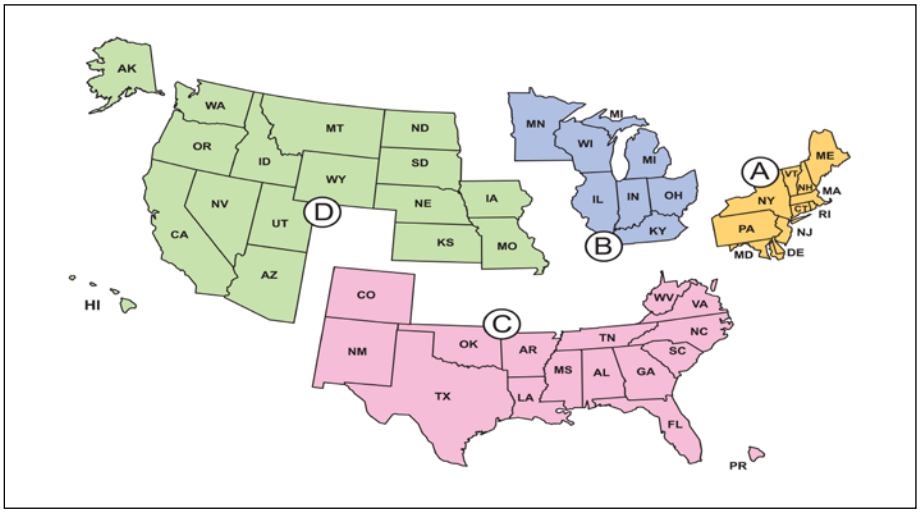
The Recovery Audit Program is an important initiative in CMS's goal to reduce improper payments and pay claims accurately. The CMS established the Medicare FFS Recovery Audit Program in early 2009 and fully implemented the program by September 2010. Each Recovery Auditor is responsible for identifying overpayments and underpayments in a geographically defined area that is roughly one-quarter of the country. In addition, the Recovery Auditors are responsible for highlighting to CMS common billing errors, trends, and other Medicare payment issues. Recovery Auditors are unique and distinct from other contractors due to their ability to conduct widespread postpayment review.

The Medicare FFS Recovery Auditors in each region in FY 2012 were:

- Region A: Performant Recovery (formally known as Diversified Collection Services)
- Region B: CGI
- Region C: Connolly
- Region D: HealthData Insights (HDI)

Figure 1 depicts each of the four Recovery Audit Program regions.

Figure 1:



Review

The Recovery Auditors review Medicare FFS claims on a post-payment[4] basis using the same Medicare policies and regulations as other Medicare contractors. The CMS limited the claims eligible for Recovery

[4] See page 21 for a discussion of the Recovery Auditor prepayment review demonstration.

Auditor review to those that were paid within the past three years. The Recovery Auditor improper payment correction process is similar to that used by other Medicare contractors and is as follows:

Recovery Auditors follow three review processes to identify improper payments: automated, semi-automated, and complex.

- **Automated**: These reviews use claims data analysis to identify improper payments.
- **Semi-Automated**: Similar to automated, these reviews are initiated with data analysis; however, providers may submit supporting documentation to substantiate the claim.
- **Complex**: This requires a review of the supporting medical records to determine whether there is an improper payment. The reviewer must be a qualified health care coder or clinician, based on the type of review being undertaken.

Notification

After the Recovery Auditor identifies an improper payment, the next step in the process is notifying the provider of the overpayment or underpayment. For automated and semi-automated reviews, the Recovery Auditors send informational letters that describe the rationale for the overpayment determination. For claims that underwent a complex review, Recovery Auditors are required to send review results letters with more detailed rationales, indicating the specific reason for the improper payment determination. Review results letters also include references utilized in reviewing the medical documents and educate providers about how to avoid similar payment errors in future Medicare billing practices.

After notification of an improper payment, providers may request a discussion with the Recovery Auditors regarding their claim determinations. The discussion period offers providers the opportunity to discuss concerns about the determination with the Recovery Auditor Medical Director and submit additional documentation relevant to the determination.to substantiate their claims. It also allows the Recovery Auditors to review the additional information without the provider having to file an appeal. If the Recovery Auditor reverses its claim determination, it will stop the claim from being adjusted, or work with the MAC to reverse the adjustment if it has already occurred. However, providers may not simultaneously initiate a discussion and an appeal. The Recovery Auditors will stop the discussion period if they are notified of a pending appeal.

In the case of an underpayment, the provider is notified via letter describing the underpayment and the repayment process. In the case of an overpayment, the provider receives a “demand” letter requesting repayment of the specific amount. The “demand” letter includes the accompanying rationale for the determination and instructs providers on the repayment and appeal processes. The CMS fully transitioned the responsibility of issuing demand letters from the Recovery Auditors to the MACs to streamline all adjustment correspondence and activities and to ensure the timeliness of demand notifications.

Collection and Repayment

The MACs are responsible for the collection efforts of overpayments and repayment of underpayments identified by the Recovery Auditors. The recoupment of an overpayment may be offset against future payments from CMS if payment is not received within the specified timeframe. The provider may also apply for an extended repayment plan. Typically, recoupment from future payments begins 41 days after

the adjustment/date of the demand letter. In addition, the receipt of a valid appeal may also delay recoupment.

Appeals

Providers who disagree with a Recovery Auditor improper payment determination may utilize the multilevel administrative appeals process. Recovery Audit appeals follow the same appeal process as other Medicare claim determinations. The levels of appeal are described below.

Redetermination:

Performed by MACs, this appeal must be received within 120 days of the initial determination, and decided by the contractor within 60 days of receipt.

Reconsideration:

Performed by Qualified Independent Contractors (QICs), this appeal must be filed within 180 days of the date of the Medicare Redetermination Notice. The QICs have 60 days to process the appeal.

Administrative Law Judge (ALJ):

This level allows a hearing, and thus more party involvement and explanation. These appeals require a minimum amount in controversy (currently $130), and must be filed within 60 days of the reconsideration notice. By Congressional mandate, the appeal should be decided within 90 days of receipt. However, current backlogs are resulting in over 200 days to decide these appeals.[5]

Medicare Appeals Council within the Departmental Appeals Board (DAB):
This level of appeal must be filed within 60 days of the ALJ decision, and is generally decided within 90 days of the request. There is no minimum amount in controversy at this level.[6]

Final Judicial Review (Federal District Court Review):

The current minimum amount in controversy for this level is $1,350. The appeal must be filed within 60 days of the appeals council notice, but the Federal Court does not have a deadline for their review.

[5] Operational expenses of appeals filed at this level are not funded through the Recovery Audit Program and recovery amounts are not reduced by appeal expenses at this level.
[6] Operational expenses of appeals filed at this level are not funded through the Recovery Audit Program and recovery amounts are not reduced by appeal expenses at this level.

Medicare FFS Key Program Components

The CMS has identified five key factors for measuring the success of the Recovery Audit program: ensuring accuracy, ensuring the program operates efficiently and effectively, maximizing transparency, minimizing provider burden, and developing robust provider education. In addition, communication with key stakeholders is essential to the program's success, as it ensures that problems and solutions are identified early and that issues are discussed with all parties.

Ensuring Accuracy

The CMS has implemented several elements to ensure Recovery Auditors are accurately identifying improper payments. All new review topics for potential audits are approved by CMS before the Recovery Auditors begin widespread review. For some complex non-coding reviews, this occurs through a CMS New Issue Review Board that is comprised of CMS policy and coverage staff and clinicians. This ensures that the appropriate CMS personnel both are aware of and approve of what the Recovery Auditors are reviewing, and that they have the correct interpretation of the policies used in their audit methodologies. During CMS New Issue Review Board meetings, coverage and policy experts review whether the Recovery Auditor's proposed review approach is consistent with current guidelines. These discussions sometimes reveal that certain guidelines may be outdated or no longer clinically appropriate. This leads to changes in updating certain coverage or billing guidelines to align with more current practice.

For other types of reviews, such as automated, semi-automated, and complex coding, CMS uses the expertise of the MACs to review potential review topics and make recommendations to CMS regarding approval. This ensures that the contractor that implemented the policy is aware of the audit and that the Recovery Auditors are correctly interpreting the policies in their region.

Recovery Auditors are also required to have at least one full time Medical Director on staff. The use of Medical Directors has proven to be a valuable addition to the program, as they provide clinical expertise on and oversight of the medical review process. The Medical Director is required to be involved in all phases of the medical review and quality assurance processes to ensure that policies are being followed and accurate review decisions are being made. The Medical Director participates in policy discussions with CMS and other Medicare contractors and offers solutions to the improper payment findings. These physicians also engage in frequent discussions with providers, which allows for greater education. Several Recovery Auditors have added additional full time or part time Medical Directors to provide greater clinical guidance and assistance to staff, providers, and CMS. Recovery Auditors also sometimes utilize specialists that are not dedicated to the Recovery Audit program, but act as resources when needed.

To ensure the accuracy of the Recovery Auditor's claim determinations, CMS uses an independent validation contractor to review a monthly random sample of claims on which the Recovery Auditors has made an improper payment determination. The Recovery Audit Validation Contractor (RVC) establishes an annual accuracy score for each Recovery Auditor. The RVC employs policy experts and clinicians, and presents CMS with an independent decision regarding the sample. The accuracy score represents how often the Recovery Auditors were accurately determining overpayments or underpayments based on

the validation contractor's review. In FY 2012, all Recovery Auditors had a cumulative accuracy score of 92 percent or higher (see Appendix K).

The RVC is also tasked with conducting special studies of Recovery Auditor findings. In FY 2012, the validation contractor performed 14 special studies on claims reviewed by all four Recovery Auditors. The CMS uses these studies to further focus on certain claim types and audit areas that may require more analysis. Including both the accuracy and special study reviews, the RVC reviewed over 5,000 claims as part of its oversight activities.

To help ensure continued oversight of the claim determinations in the Recovery Audit Program, CMS had a full and open competition among 8(a) small business vendors to award a new validation contract in FY 2012 after the current contract ended in FY 2011.[7]

Ensuring the Program Operates Efficiently and Effectively

The CMS works to make the Recovery Audit Program as efficient and effective as possible by minimizing provider impact and administrative cost.

One of the keys to improving efficiencies is continued communication between all stakeholders. The CMS provides several opportunities for discussion among contractors to address operational issues and concerns that may impede program efficiency. In the last year, CMS has increased these communication opportunities and hosts regularly scheduled conference calls for the Recovery Auditors and MACs to discuss ongoing issues. Increased contractor relations have resulted in more continuous claim processing, changes in the operational process to allow for more streamlined communications, and contractor sharing of identified program vulnerabilities for potential review.

The CMS also continues to improve the Recovery Audit Data Warehouse to track greater audit detail and information. The Recovery Audit Data Warehouse was developed to serve as the primary source of data for the Medicare FFS Recovery Audit Program. The CMS continues to improve the Recovery Audit Data Warehouse functionalities to allow more data storage and collection and automating the process of data collection as much as possible. The CMS hosts additional communications dedicated to Recovery Audit Data Warehouse operational issues.

The CMS is continuing to use esMD to allow providers to electronically submit documentation. In an increasingly electronic medical record environment, this eliminates the costly and time-consuming need for providers to mail hard-copy records for contractor review. In FY 2012, all Recovery Auditors were voluntary participants in the program.

Maximizing Transparency

In order to promote transparency, CMS posts improper payment corrections information, including overpayments and underpayments, on a quarterly basis on its website.[8] The CMS also posts the Recovery Auditor statement of work and educational articles aimed at preventing future improper payments. The

[7] The CMS awarded this contract to Provider Resources Inc,.
[8] This information is posted at www.cms.gov/recovery-audit-program.

individual Recovery Auditor websites contain all of the topics approved for review, called "issues," with search functions to improve the ease of provider navigation.

Recovery Auditors are required to use web portals to allow providers to review claim status information and track the progress of their audits. Recovery Auditors have expanded their use of the portals to include demand letter information and review rationales for their improper payment determinations. Some Recovery Auditors also use the portal to deliver messages to the provider communities in their region about specific audits, such as details about an audit that may have been stopped, discussion period instructions, and other information that may be helpful to providers as they respond to a request for additional documentation.

The CMS meets regularly with national, state, and local provider and supplier associations as well as other interested stakeholders to discuss operational concerns about the Recovery Audit Program. New ideas and improvements are often discussed at these meetings and CMS values the input of the associations and the providers on the aspects of the program.

Minimizing Provider Burden

The CMS is sensitive to the concerns of the provider and supplier communities and continues to work with these communities to reduce the burden of the review process. The CMS has imposed additional documentation request limits on the number of medical records a Recovery Auditor may request in a 45-day timeframe. The limits establish continuity and help providers prepare for potential audits, as well as encourage the Recovery Auditors to select only those claims with the highest risk of improper payment. Appendix J shows the rate of which additional documentation requests result in improper payments for each Recovery Auditor. As previously discussed, all Recovery Auditors accept esMD submissions to minimize provider and supplier burden associated with medical documentation requests. The limits and the acceptance of esMD help to minimize the time necessary to respond to Recovery Auditor requests and offers another alternative for providers to safely and quickly transport the documentation. The CMS understands that additional staffing is often required to address Recovery Auditor correspondence and it is constantly working to ensure providers can respond to requests without affecting beneficiary care.

Each Recovery Auditor has a customer service center with representatives available to address provider concerns. They are required to have a quality assurance program to ensure that all customers receive professional and knowledgeable assistance with timely follow up when necessary. Personnel are required to return telephone calls within one day, respond to electronic inquiries within two days, and respond to written requests within 30 days. The MACs are also available to address any Recovery Audit Program questions dealing with claims adjustment, recoupment, and appeals.

In addition to efforts in the Recovery Audit Program, CMS works across the agency to minimize provider burden. These efforts include ensuring that claims reviewed by one entity are not reviewed by another contractor again, unless there is a concern of potential fraud. The CMS also works to ensure that multiple review entities such as Recovery Auditors, MACs, and ZPICs are not reviewing the same providers and the same topics at the same time. The CMS is exploring additional options to help providers navigate through the audit process. Initiatives include enhancing CMS websites with consolidated contractor information, standardizing documentation request letters, and standardizing medical review timeframes. The CMS understands that some providers utilize additional staffing to help manage the requirements of

the Recovery Audit Program and is constantly working to streamline program operations as much as possible.

Developing Robust Provider Education

The Recovery Audit Program identifies areas for potential improper payments and offers an opportunity to provide feedback to providers on future improper payment prevention. The CMS encourages collaboration between Recovery Auditors and MACs to discuss improvements, areas for possible review, and corrective actions that could prevent improper payments. Educational efforts include articles or bulletins providing narrative descriptions of the claim errors identified and suggestions for their prevention, as well as system edits for errors that can be automatically prevented at the onset. These efforts are described more in the Corrective Action section of this report.

The CMS hosts regular conference calls between the Recovery Auditors, MACs, and CMS policy and clinical staff to discuss audits that have resulted in large amounts of improper payments and present vulnerabilities to the Medicare trust funds. These discussions help to ensure uniformity in policy application, and discuss methods for correction and future trust fund protection. The CMS and other contractors use these calls to discuss future corrective actions, whether local system edits and/or education can be effective, or if national system edits or education is necessary.

In addition, CMS has partnered with state and national hospital associations to provide periodic updates via conferences, webinars, and teleconferences. These forums serve as an opportunity for CMS to gain the insight of the provider community as well as provide feedback from the program to providers.

Medicare FFS FY 2012 Results

Overview

In FY 2012, the Recovery Auditors identified and corrected $2.4 billion in improper payments. There were $2.3 billion collected overpayments and $109.4 million identified underpayments paid back to providers (see Appendix C).

After taking into consideration all costs, underpayment determinations that are paid to providers, and appeal reversals, the Medicare FFS Recovery Audit Program returned $1.9 billion to the Medicare trust funds in FY 2012 (see Appendix B). The CMS spent $228.1 million to operate the Medicare FFS Recovery Audit Program, of which $142.3 million were contingency fees paid to Recovery Auditors. Administrative costs such as processing appeals, adjusting claims, support contractors, and oversight of the program accounted for the additional $85.8 million. Because the amount of improper payments that were identified in FY 2012 increased significantly over last year, the administrative costs to process the additional claims and appeals increased as well.

HDI had the most corrections in terms of both overpayments and underpayments. See Appendix C for corrections information broken down by each state. A majority of the improper payments were from Part A claims, with a small portion coming from Part B claims, and the fewest coming from DME claims (Appendix E). Appendix F shows the breakdown of improper payment corrections by both claim type and Recovery Auditor.

Over 91 percent of these overpayments (more than $2 billion) are from inpatient hospital claims (Appendices G and H). Many of the top overpayment determinations in FY 2012 were due to short-stay inpatient hospital admissions. Many short-stay inpatient hospital services should have been provided in the outpatient setting and the documentation fails to demonstrate medical necessity for the inpatient setting. These admissions also represented a significant portion of Medicare's FFS improper payment rate. The CMS is exploring several ways to help reduce these types of errors which are discussed more in-depth in the next section of this report.

Although the Recovery Auditors performed more automated reviews (over 67 percent of all claims reviewed) than semi-automated and complex reviews, the vast majority of the improper payments collected came from complex reviews (over 91 percent). Appendix I shows more information about improper payments and claim corrections by the type of review performed.

Appeals

The CMS strives to lower the appeal rate to decrease provider burden and administrative costs of the program. In FY 2012, only 7 percent of all Recovery Auditor determinations have been challenged and later overturned on appeal (see Appendix L). Medicare providers appealed 373,259 claims, which constitute 26.3 percent of all claims with overpayment determinations. Of those claims appealed, 99,476 claims were overturned with decisions in the provider's favor (26.7 percent).

Appeals are overturned for a variety of reasons including:

- ALJs are bound by Medicare statute, National Coverage Determinations (NCDs), and CMS rulings. ALJs are required to provide deference but are not bound by CMS manuals or Local

Coverage Determinations (LCDs). Recovery Auditors are required to make their claim decisions based on all CMS policies including manuals and LCDs. This creates inconsistencies between the ALJ decisions and the Recovery Auditor decisions. [9]

- In many Part B denials providers can easily correct and resubmit some claims after the overpayment determination. For example, they can add a missing modifier to the claim that makes it payable.
- Providers often produce additional documentation that was not provided to the Recovery Auditor at the time they made their original decision. Recovery Auditors give providers multiple attempts to provide documentation supporting their claim. However, it sometimes is only produced when a provider receives an overpayment determination and then subsequently files an appeal.

The receipt of an appeal and the reversal of a Recovery Auditor decision do not necessarily mean the Recovery Auditor was incorrect in its determination. Automated and Semi-Automated reviews are often denied correctly. However, as noted above, the provider can correct the claim during the appeals process by adding a modifier, correcting the number of units of service, or modifying the claim so that it follows CMS policy for payment. In these cases, the Recovery Auditor was correct in its determination. The CMS believes these corrections should be reported as a separate category and continues to improve data sharing and reporting capabilities between contractors to try and account for these corrections.

The CMS has made changes to the review approval process to even further improve the Recovery Auditors identifications, as well as the appeals overturn rate. The CMS now requires the MACs to validate the Recovery Auditors proposed review methodology and policy interpretations for their particular jurisdictions to minimize incorrect findings. While the review approval process should minimize these occurrences, CMS works quickly to resolve the issue so the provider can avoid the burden of the appeals process when they do occur.

Recovery Auditors continued to increase their participation in ALJ appeal hearings. Appeals involvement by Recovery Auditors aids in contractor and provider education, as it presents an additional forum for discussion and can identify incorrect billing practices to the provider and CMS policies in need of further clarification. This also presents an opportunity for the Recovery Auditors to clarify any policy questions the ALJ(s) may have during the hearing process.

Short-Stay Inpatient Hospital Admission Claims

The majority of the FY 2012 Recovery Audit Program appeals at the ALJ level focused on short-stay inpatient hospital claims that had overpayment determinations based on inpatient admissions that were not medically necessary. The Recovery Auditor determined from the medical documentation that it was not medically necessary for the patient to be admitted as a hospital inpatient because the patient could have been safely and effectively treated as an outpatient. Increased appeals for these types of claims have led to backlogs at the OMHA. OMHA has a number of options when considering an appeal, including:

- Issuing a fully favorable decision based on the evidence submitted in the administrative record;
- Conducting a video, telephone, or in-person hearing for all parties and participants of the case; or

[9] http://oig.hhs.gov/oei/reports/oei-02-10-00340.pdf

- Under certain circumstances, remanding the case back to the QIC if evidence is missing from the administrative record.

Existing policy allowed providers who received these type of inpatient admission denials described above to only rebill for a limited number of ancillary Part B services. However, the ALJs have ordered payment of all reasonable and necessary Part B services that would have been provided if the patient received services as an outpatient. Many of these cases have been remanded back to the QICs for them to determine the difference in payment between the incorrect inpatient hospital setting and the correct outpatient hospital setting. Although these decisions are considered favorable to the provider, the ALJs agreed with the Recovery Auditor's determination that the inpatient admissions were not reasonable and necessary.

The CMS is taking a number of steps to help address the confusion surrounding this issue, as well as to reduce the number of these appeals. The CMS issued Ruling 1455–R (78 FR 16614) on March 13, 2013, which expanded rebilling for Part B services. Specifically, it provides that when a Part A claim for a hospital inpatient admission is denied by a Medicare review contractor because the inpatient admission was not reasonable and necessary, the hospital may submit a Part B inpatient claim for payment for the Part B services that would have been payable to the hospital had the beneficiary originally been treated as an outpatient rather than admitted as an inpatient, except when those services specifically require an outpatient status. In addition, the Ruling established a standard process for effectuating the DAB and ALJ decisions requiring rebilling of denied Part A inpatient hospital claims under Part B, and addressed the scope of administrative review in these and other, similar cases. This ruling was intended as an interim measure until CMS finalized policies through rulemaking to address the issues raised by these decisions going forward.

The CMS solicited public comments in the CY 2013 Hospital Outpatient Prospective Payment System proposed rule for the hospital outpatient prospective payment system on potential clarifications or changes to policies regarding patient status in a hospital. In response, CMS has released several clarifications pertaining to this issue. As part of the FY 2014 Hospital Inpatient Prospective Payment System (IPPS) final rule (78 FR 50495), CMS provided clarifying policy regarding when a Medicare beneficiary qualifies for hospital inpatient admission and how Medicare review contractors will review hospital inpatient claims for Part A payment purposes. In addition, CMS revised its Part B inpatient payment policy to allow payment under Part B for all hospital services that were furnished and would have been reasonable and necessary if the beneficiary had been treated as a hospital outpatient, rather than admitted to the hospital as an inpatient (except when those services specifically require an outpatient status at the time they are provided, such as observation services). Under the final rule, CMS specified that a 1-year timely filing restriction will apply to the billing of all Part B inpatient services.

The final rule also modifies and clarifies CMS's longstanding policy on how Medicare contractors review inpatient hospital admissions for payment purposes. Under this final rule, in addition to services designated as inpatient-only, surgical procedures, diagnostic tests and other treatments are generally appropriate for inpatient hospital admission and payment under Medicare Part A when the physician (1) expects the beneficiary to require a stay that crosses at least two midnights and (2) admits the beneficiary to the hospital based upon that expectation.

The admissions guidance and rebilling policies released as part of the FY 2014 Hospital IPPS final rule became effective for inpatient admissions with dates of admission on October 1, 2013. The provisions published as part of the final rule should result in greater consistency in hospital billing and, as a result, reduce the incidence of improper payments in the Medicare FFS program, which in turn reduces the number of appeals resulting from those improper payments.

Medicare FFS Corrective Actions

The CMS continues to improve its process of developing corrective actions to prevent improper payments. The development of corrective actions is an agency-wide collaborative effort.

The CMS has established a process to take corrective actions for program vulnerabilities based on Recovery Auditor reviews. Recovery Auditors request approval from CMS to review different types of claims. The request can be based on a particular code or group of codes, a particular setting, or any number of factors. These approved review areas are referred to as "issues." Recovery Auditors post these issues to their individual websites. In FY 2012, if the same issue was approved for each of the four Recovery Audit regions, CMS initially considered those four separate issues instead of one issue.

Definition and Identification of Vulnerabilities

The causes of improper payments for issues are often similar and can be addressed with similar corrective actions. The CMS analyzes all issues with more than $500,000 in Recovery Audit corrections and groups them into vulnerabilities. A vulnerability is defined as a claim type (or series of related claim types) that pose a financial risk to the Medicare FFS program because they are most susceptible to improper payment due to lack of medical necessity, incorrect coding or lack of documentation.

The CMS develops national claims processing system edits to prevent future improper payments. These edits can deny a claim or send an electronic message to the MACs to manually review a claim. An example of a vulnerability that has been corrected by a national claims processing system edit is place of service coding for physicians. Physicians perform procedures in both the office and hospital setting and are paid accordingly depending on the setting. Hospitals also submit a claim when services are furnished by a physician and they receive additional payment for such procedures to account for additional overhead costs. Some physicians submit claims with the incorrect place of service coded. Because physicians and hospitals bill at different times, an edit was implemented to either deny the claim or send an electronic message to the MAC to monitor additional claim submissions to determine the correct place of service of the physician claim.

MACs also develop edits for their local claim processing systems based on identified improper payments for their jurisdiction. The CMS develops medically unlikely edits that deny claims where the services billed exceed a number that would be clinically reasonable. The CMS updates these edits quarterly. The CMS also develops National Correct Coding Initiative (NCCI) edits to catch those services that are coded incorrectly and updates these edits quarterly as well.

Vulnerabilities identified through automated review may be corrected by a national claims processing system edits, medically unlikely edits, or NCCI edits. However, those identified through complex review cannot be corrected by an edit and may need to be corrected through provider education, pre-payment review, or changes in CMS policy. Semi-automated review vulnerabilities are included in the complex category since they also cannot be corrected by an edit. (Refer to page five for the definitions of automated, semi-automated, and complex reviews.)

Summary of FY 2012 Vulnerabilities[10]

The CMS prioritizes vulnerabilities based on dollar amount corrected, as well as the date the vulnerability was identified. In FY 2012, CMS identified 31 vulnerabilities through the Recovery Audit Program. Twenty- seven of the 31 vulnerabilities were identified through automated review and four were identified through complex review. As of September 30, 2012, the Recovery Auditors corrected $2.3291 billion in improper payments based on these vulnerabilities.

Corrective Actions for Automated Vulnerabilities

Vulnerabilities that have been addressed:

The CMS works to address Recovery Auditor identified vulnerabilities as soon as possible to prevent future improper payments. However, some vulnerabilities identified in FY 2012 generally will not have claims processing edits implemented until successive years. It is possible that claims processing edits are already in place for particular vulnerabilities, but need to be re-evaluated for effectiveness. It is also possible that edits have been implemented more recently, but the effects of the edit have not yet been realized. Below is a summary of edits that relate to the 27 automated vulnerabilities identified in FY 2012.

- The CMS implemented edits to resolve two automated vulnerabilities in FY 2012.
- The CMS implemented one edit in FY 2013 to resolve an automated vulnerability from FY 2012.
- The CMS already had in place edits related to four FY 2012 automated vulnerabilities; these edits will be re-evaluated for effectiveness.
- Three vulnerabilities involve Medically Unlikely Edits (MUEs), which have been implemented through quarterly updates.
- Three vulnerabilities involve National Correct Coding Initiative (NCCI) edits, which have been implemented through quarterly updates.

Vulnerabilities that have been addressed but are awaiting implementation:

- The CMS drafted edits for four FY 2012 automated vulnerabilities, with implementation dates in FY 2014.
- The CMS plans to draft edits for three additional FY 2012 vulnerabilities in FY 2013.

Other Vulnerabilities:

The CMS cannot create national claims processing edits for seven automated vulnerabilities. These vulnerabilities are based on LCDs and require local system edits by the MACs. Although the MACs receive regular notification of all Recovery Auditor vulnerabilities through contractor conference calls and technical direction letters, they have limited resources with which to implement their edits. Through their Medical Review Strategy report, which identifies the areas on which they plan to perform medical

[10] Senate Committee Report 112-176 requested the inclusion of Recovery Auditor identified vulnerabilities in the annual Medicare FFS Recovery Audit Report to Congress. (U.S. Senate. Committee on Appropriations. Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Bill, 2013, (to Accompany S. 3295) (112 S. Rpt. 176))

review, the ERRP, and other data analysis, MACs prioritize the areas most subceptable to improper payments that would most benefit from local system edits. The MACs work to correct vulnerabilities in other ways, such as additional medical review (both prepayment and postpayment) and provider education.

Corrective Actions for Complex Vulnerabilities

The CMS has initiated several corrective actions to address complex vulnerabilities.

As indicated in the Results section on page 13, CMS provided clarifying policies regarding when a Medicare beneficiary qualifies for hospital inpatient admission and how Medicare review contractors will review hospital inpatient claims for Part A payment purposes, as part of the FY 2014 Hospital IPPS final rule . The CMS believes that this clarification will reduce the incidences of beneficiaries being improperly admitted for inpatient hospital care, which will result in fewer improper payments.

To help prevent improper payments from occurring, CMS has implemented a demonstration to allow Recovery Auditors to review claims before they are paid. Because these complex vulnerabilities require a full review of the medical record, increasing the number of claims reviewed prior to payment is the most effective way to ensure that CMS does not pay for claims that are noncovered, incorrectly coded, or not medically necessary. The CMS believes that the immediate identification of incorrect claims provides quick feedback and education to providers who can then correct the problem. The CMS has prioritized the most significant improper payments by error type, provider type and state. More information on this demonstration can be found on page 21.

The CMS is also testing a change in payment policies, requiring prior authorization for power mobility devices, which have historically had extremely high rates of improper payments. In September 2012, CMS implemented the Prior Authorization of Power Mobility Device (PMD) demonstration for people with Medicare who reside in seven states with high incidences of fraud and improper payments. Through the use of prior authorization, this demonstration will help ensure that a beneficiary's medical condition warrants their medical equipment under existing coverage guidelines. By ensuring that all Medicare requirements are met prior to payment, this reduces the amount of improper payments. Providers can leverage the esMD program to submit documentation for this demonstration, which would help shorten the length of time necessary to approve a device.

The CMS requires its contractors to review and validate the improper payment data for their jurisdictions. The CMS sends technical direction letters to its contractors on a quarterly basis. Responses to technical direction letters are tracked in the CMS Program Vulnerability Tracking System. The technical direction letters require the contractors to determine if selected Recovery Auditor review topics are areas of improper payments in their jurisdictions, and determine the education, outreach, and review strategies needed to reduce improper payments. Contractors can conduct probe reviews (evaluation of a small sample of medical records) to identify potential problem areas. Based on probe results, CMS and its contractors take corrective actions to prevent the continuation of improper payments, such as increased or more targeted prepayment or postpayment reviews. The CMS requires its contractors to develop ERRPs that identify the specific cause of improper payments in their jurisdictions and outline corrective actions.

The CMS has issued numerous educational materials, including four Quarterly Provider Compliance Newsletters and MLN Matters articles in FY 2012. The CMS has received positive feedback from provider associations regarding the value of these documents, and plans to continue their issuance. These articles are available at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/ProviderCompliance.html. The CMS contractors also post MLN Matters articles to their websites as well as other education material relevant to CMS policy and Local Coverage Determinations (LCDs) for their jurisdiction. National policy guidance is available for web viewing at http://www.cms.gov/medicare-coverage-database.

Medicare FFS Continuous Improvement

The CMS is committed to working with the Recovery Auditors, the provider and supplier communities, and other stakeholders to continuously improve the program and refine ongoing operations.

Recovery Auditors continue to participate and encourage providers to participate in the esMD program, which facilitates the paperless transmission of electronic medical records. Provider participation varies across Recovery Auditors, but is as high as 18 percent of all documentation submitted to Connolly, the Recovery Auditor in Region C. For Performant, the Recovery Auditor in Region A, participation has increased 4 percent over the course of FY 2012. This program promotes both efficiency and organization, while reducing provider burden and administrative costs. The CMS anticipates even higher participation in FY 2013.

The CMS encourages the Recovery Auditors and claims processing contractors to meet to discuss program issues and potential improvements. In FY 2012, CMS held an onsite meeting with all MACs and Recovery Auditors. In addition, CMS hosts regular teleconference meetings. These serve as a forum to focus on clinical issues, appeals, operational issues, and best practices. By nurturing contractor collaboration, CMS helps to:

- Ensure uniform policy application;
- Limit inaccurate identifications by the Recovery Auditors based on different interpretations of the policy;
- Limit unnecessary appeals to reduce provider burden and costs; and
- Ensure review topics are not being reviewed by more than one Medicare fee-for-service entity to further reduce provider and supplier burden.

The CMS also continues to encourage Recovery Auditors to review all claim types. In FY 2011, CMS modified the Statement of Work for the Recovery Auditors and added more emphasis on the review of all claim types with a high error rate. All four Recovery Auditors are approved to review certain Home Health and Inpatient Rehabilitation Facility topics. Other new provider types under review in FY 2012 include Skilled Nursing Facilities, Critical Access Hospitals, and Hospice. At times, CMS also refers review topics to the Recovery Auditor, including referrals from the Health and Human Services (HHS) Office of Inspector General reports.

The CMS regularly evaluates the Recovery Auditors' performance and adherence to the requirements in their Statement of Work. Staff members go on location to observe medical reviewers, IT systems, and customer service areas. When onsite visits are not possible, CMS conducts desk audits on claims to confirm that all aspects of the review process were completed correctly and accounted for in the Data Warehouse. Regular meetings with claims processing contractors, provider groups, and other stakeholders are also monitored for additional contractor oversight. If there are any findings in these evaluations, CMS notifies the Recovery Auditor and requires a corrective action plan. The results of these regular evaluations are consolidated annually in the Contractor Performance Assessment Rating System (CPARS) for an overall performance rating for the year. These results are available to all federal

agencies. The CMS believes that regular contractor oversight is essential to the success of the Recovery Audit Program.

Medicare FFS Program Development

As part of CMS's comprehensive plan to reduce the improper payment rate, CMS is exploring several options to improve the Recovery Audit Program. In the FY 2014 President's Budget, CMS included a legislative proposal to retain a portion of Recovery Audit recoveries to implement actions that prevent improper payments including those from fraud and abuse. The CMS understands the importance of implementing corrective actions to reduce the amount of improper payments; however, CMS does not have a dedicated source of funding for addressing these Recovery Audit Program findings. The FY 2014 budget proposal would provide funding to further investigate the underlying causes of the improper payments and revise policies, conduct additional targeted prepayment review, perform provider education and implement additional pre-payment edits, as appropriate.

In September 2012, CMS began a demonstration allowing Recovery Auditors to conduct prepayment review on inpatient hospital claims, as these historically have high rates of improper payments. Instead of reviewing claims after they are paid and then recouping any incorrectly paid funds, this demonstration would allow Recovery Auditors to review claims before they are paid to ensure that the provider has complied with all CMS coverage and billing rules. If the Recovery Auditor review finds that the claim is billed correctly, then the claim is paid. If the claim is not billed correctly then it is denied. The Recovery Auditor receives its contingency fee on the amount of the claim they prevented from being improperly paid. The demonstration affects seven states with high incidences of improper payments and fraud (Florida, California, Michigan, Texas, New York, Louisiana and Illinois), as well as four states with the high numbers of short hospital stays (Pennsylvania, Ohio, North Carolina and Missouri). The demonstration is evaluating whether the increased amount of prepayment reviews can have a significant impact on lowering the error rate and lowering the risk of fraudulent claims.

The CMS also implemented a demonstration that allowed participating hospitals to rebill for Part B services when a Part A inpatient short-stay claim is denied on the basis that the inpatient admission was determined not medically necessary. Before CMS Ruling CMS-1455-R was issued, providers were not able to rebill for the individual services provided during the denied inpatient stay except for a very limited list of ancillary "Part B Only" services, and only within the 1-year timely filing period. Under this demonstration, hospitals could rebill for all Part B services that would have been reasonable and necessary had the beneficiary been treated as an outpatient, rather than admitted as an inpatient. This demonstration was intended to allow CMS to evaluate the effectiveness of these new methods of allowing rebilling and resubmission of inpatient claims where inpatient admissions were denied as not reasonable and necessary. On March 13, 2013, the Part A to Part B Rebilling Demonstration was terminated with the release of CMS Ruling CMS-1455-R.[11]

As mentioned above, CMS is constantly working with impacted stakeholders such as the HHS OIG, Government Accountability Office, other CMS components, and outside referrals to determine new areas

[11] This Ruling was an interim measure until CMS finalized a rebilling policy through rulemaking. Part B rebilling policies were included in the FY 2014 IPPS Final Rule, effective October 1, 2013.

for Recovery Audit review. The CMS will continue to explore new areas to utilize Recovery Auditors in the future.

Status of the Recovery Audit Program for Medicare Advantage (Part C), Medicare Prescription Drug (Part D), and Medicaid Programs

Medicare Parts C and D RACs

Section 6411 (b) of the Affordable Care Act expanded RACs to Medicare Parts C and D. The Part D RAC is dedicated to identifying improper payments previously paid to Part D plan sponsors in reconciled Medicare Prescription Drug Events (PDEs) and to provide information to CMS to help prevent future improper payments. The contract to perform Part D RAC work was awarded on January 13, 2011. The Part D RAC's initial review focused on identifying improper payments for prescriptions written by excluded prescribers or filled by excluded pharmacies beginning with the 2007 contract year. Recoupment of approximately $2 million in overpayments began in the first quarter of FY 2013 for those plan sponsors identified during the RAC's initial audit review. The Part D RAC is continuing its review of the 2008 through 2011 excluded prescribers and pharmacies. Notification of Improper Payment letters totaling $3.4 million were sent to Part D plan sponsors during the 3rd quarter of FY 2013.

To provide additional public information about the Part D RAC program, CMS added a Part D RAC informational page to the CMS website on January 19, 2012. This page includes a description of the RAC's authority and functions, the audit topics intended for review, as well as the procedures used for review. The CMS is currently developing additional forums where Parts C and D plan sponsors and the public can obtain Part D RAC information. The CMS determined priority areas for review. In addition to the Part D RAC activity, CMS posted a Sources Sought Notice on April 4, 2013, seeking potential contractors to perform Part C RAC activities. Review of the responses will take place during the 3rd quarter of FY 2013.

Medicaid RACs

State Medicaid agencies contract with Medicaid RACs to identify and recover overpayments, and identify underpayments made to Medicaid providers. The CMS issued a final rule implementing section 6411(a) of the Affordable Care Act in September 2011 requiring states to implement Medicaid RAC programs by January 1, 2012.[12]

States may request exceptions to the final rule provisions by submitting State Plan amendments (SPAs) for CMS's review and approval. During FY 2012, states requested and received approval for several types of exceptions. For example, CMS approved states' requests to delay the required effective implementation date of January 1, 2012, extend the 3-year maximum claims look back period, and modify or exclude the requirement that their RAC vendors hire a full-time Contractor Medical Director. As of

[12] The September 16, 2011 Medicaid RAC final rule is available online at http://www.gpo.gov/fdsys/pkg/FR-2011-09-16/pdf/2011-23695.pdf.

September 30, 2012, 36 states had implemented Medicaid RAC programs. The CMS granted five U.S. territories complete exceptions from implementing RAC programs because they did not have the necessary Medicaid claims data infrastructure to support a RAC program. Additionally, time-limited exceptions from implementing Medicaid RAC programs were approved for three states. Florida and Vermont were granted exceptions because of their high rates of Medicaid managed care penetration, and South Dakota was granted an exception due to its small Medicaid beneficiary population, low associated expenditures, low Medicaid payment error rate, and existing Medicaid integrity efforts. The CMS is working with the remaining 11 States and D.C. to implement their Medicaid RAC programs. For FY 2012, the states have recovered a total Federal and State share combined amount of $95.64 million and returned a total of $57.57 million to the Treasury through the state Medicaid programs. The majority of states are in the early stages of initiating audit operations. The CMS expects recoveries to increase as more states have fully operational State Medicaid RAC programs.

During FY 2012, CMS's role in Medicaid RAC programs focused on providing guidance to states as they implemented their Medicaid RAC programs, monitoring the progress of those programs, and encouraging states to make their Medicaid RAC programs as transparent as possible. The Medicaid RACs-At-A-Glance web portal is a tool, developed by CMS, that facilitates transparency and monitoring of the progress of Medicaid RAC programs.[13] The CMS launched the Medicaid RACs-At-A-Glance (Phase II) web portal in September 2012. Phase II features state-reported information on each state's Medicaid RAC program, including contact information for each state Program Integrity Director, the name of each RAC vendor and RAC Medical Director, contingency fee rates for the identification and recovery of overpayments, payment methodologies for the identification of underpayments, user-friendly charts and data, and state profile pages. The CMS continued to develop additional enhancements to the Medicaid RACs-At-A-Glance web portal which, when completed, will collect state-reported Medicaid RAC program performance data. Those data will form the basis of future reports to Congress on the effectiveness of Medicaid RAC programs. Additionally, CMS provided guidance and technical assistance to states through webinars and teleconferences during FY 2012. Topics included Medicare Best Practices: Technical Assistance for states, CMS–64: RAC Reporting of Recoveries for states, RAC Fraud Referrals to the state Medicaid Agencies, Performance Metrics, and state-user training for RACs-At-A-Glance Phase II.

[13] The Medicaid RACs-At-A-Glance website is available at http://w2.dehpg.net/RACSS/Map.aspx.

Appendices

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Appendix A1:

Social Security Act

SEC. 1893 MEDICARE INTEGRITY PROGRAM

(h)[393] USE OF RECOVERY AUDIT CONTRACTORS.—

(1) IN GENERAL.—Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this title with respect to all services for which payment is made under this title. Under the contracts—

(A) payment shall be made to such a contractor only from amounts recovered;

(B) from such amounts recovered, payment—

(i) shall be made on a contingent basis for collecting overpayments; and

(ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and

(C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

(2) DISPOSITION OF REMAINING RECOVERIES.—The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary under paragraph (1)(C) shall be applied to reduce expenditures under this title.

(3) NATIONWIDE COVERAGE.—The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010 (not later than December 31, 2010, in the case of contracts relating to payments made under part C or D).

(4) AUDIT AND RECOVERY PERIODS.—Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under this title—

(A) during such fiscal year; and

(B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

(5) WAIVER.—The Secretary shall waive such provisions of this title as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).

(6) QUALIFICATIONS OF CONTRACTORS.—

(A) IN GENERAL.—The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this title or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

(B) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1816, a carrier under section 1842, or a medicare administrative contractor under section 1874A.

(C) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY.—In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under title XIX, or under this title.

(7) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD.—A recovery of an overpayment to a individual or entity by a recovery audit contractor under this subsection shall not

be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(8) ANNUAL REPORT.—The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this title.

(9) SPECIAL RULES RELATING TO PARTS C AND D.—The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—

(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

(C) examine claims for reinsurance payments under section 1860D–15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.

Appendix A2:

Affordable Care Act

SEC. 6411. EXPANSION OF THE RECOVERY AUDIT CONTRACTOR (RAC) PROGRAM.
(a) EXPANSION TO MEDICAID.—
(1) STATE PLAN AMENDMENT.—Section 1902(a)(42) of the Social Security Act (42 U.S.C. 1396a(a)(42)) is amended—

(A) by striking ‘‘that the records’’ and inserting ‘‘that—
‘(A) the records’’;

(B) by inserting ‘‘and’’ after the semicolon; and

(C) by adding at the end the following: ‘‘(B) not later than December 31, 2010, the State shall—

‘‘(i) establish a program under which the State contracts (consistent with State law and in the same manner as the Secretary enters into contracts with recovery audit contractors under section 1893(h), subject to such exceptions or requirements as the Secretary may require for purposes of this title or a particular State) with 1 or more recovery audit contractors for the purpose of identifying underpayments and overpayments and recouping overpayments under the State plan and under any waiver of the State plan with respect to all services for which payment is made to any entity under such plan or waiver; and
‘‘(ii) provide assurances satisfactory to the Secretary that—

‘‘(I) under such contracts, payment shall be made to such a contractor only from amounts recovered;

‘‘(II) from such amounts recovered, payment—

‘‘(aa) shall be made on a contingent basis for collecting overpayments; and

‘‘(bb) may be made in such amounts as the State may specify for identifying underpayments;

‘‘(III) the State has an adequate process for entities to appeal any adverse determination made by such contractors; and ‘

‘(IV) such program is carried out in accordance with such requirements as the Secretary shall specify, including—

‘‘(aa) for purposes of section 1903(a)(7), that amounts expended by the State to carry out the program shall be considered amounts expended as necessary for the proper and efficient administration of the State plan or a waiver of the plan;

‘‘(bb) that section 1903(d) shall apply to amounts recovered under the program; and

‘‘(cc) that the State and any such contractors under contract with the State shall coordinate such recovery audit efforts with other contractors or entities performing audits of entities receiving payments under the State plan or waiver in the State, including efforts with Federal and State law enforcement with respect to the Department of Justice, including the Federal Bureau of Investigations, the Inspector General of the Department of Health and Human Services, and the State Medicaid fraud control unit; and’’.

(2) COORDINATION; REGULATIONS.—

(A) IN GENERAL.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall coordinate the expansion of the Recovery Audit Contractor program to Medicaid with States, particularly with respect to each State that enters into a contract with a recovery audit contractor for purposes of the State’s Medicaid program prior to December 31, 2010.

(B) REGULATIONS.—The Secretary of Health and Human Services shall promulgate regulations to carry out this subsection and the amendments made by this subsection, including with respect to conditions of Federal financial participation, as specified by the Secretary.

(b) EXPANSION TO MEDICARE PARTS C AND D.—Section 1893(h) of the Social Security Act (42 U.S.C. 1395ddd(h)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title'';

(2) in paragraph (2), by striking ''parts A and B'' and inserting ''this title'';

(3) in paragraph (3), by inserting ''(not later than December 31, 2010, in the case of contracts relating to payments made under part C or D)'' after ''2010'';

(4) in paragraph (4), in the matter preceding subparagraph (A), by striking ''part A or B'' and inserting ''this title''; and

(5) by adding at the end the following:

''(9) SPECIAL RULES RELATING TO PARTS C AND D.—The Secretary shall enter into contracts under paragraph (1) to require recovery audit contractors to—'

'(A) ensure that each MA plan under part C has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(B) ensure that each prescription drug plan under part D has an anti-fraud plan in effect and to review the effectiveness of each such anti-fraud plan;

''(C) examine claims for reinsurance payments under section 1860D–15(b) to determine whether prescription drug plans submitting such claims incurred costs in excess of the allowable reinsurance costs permitted under paragraph (2) of that section; and

''(D) review estimates submitted by prescription drug plans by private plans with respect to the enrollment of high cost beneficiaries (as defined by the Secretary) and to compare such estimates with the numbers of such beneficiaries actually enrolled by such plans.''.

(c) ANNUAL REPORT.—The Secretary of Health and Human Services, acting through the Administrator of the Centers for Medicare & Medicaid Services, shall submit an annual report to Congress concerning the effectiveness of the Recovery Audit Contractor program under Medicaid and Medicare and shall include such reports recommendations for expanding or improving the program.

Appendix B: Amount Returned to the Medicare Trust Funds (in Millions) from the FFS Recovery Audit Program

Overpay-ments Collected	-	Underpay-ments Restored	-	Amount Over-turned on Appeal	-	Recovery Auditor Contin-gency Fees	-	CMS Admini-stration Costs	=	Amount Returned to Medicare Trust Funds
$2,291.4		*$109.4*		*$21.3*		*$142.3*		*$85.8*		***1,932.6***

Note: CMS administration costs include adjusting claims, hearing appeals, supporting contractors, and CMS Full Time Equivalents.

Appendix C: FY 2012 Medicare FFS Corrections by Recovery Auditor

Corrections by Recovery Auditor						
	Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	No. of Claims	Amount Collected	No. of Claims	Amount Restored	No. of Claims	Amount Corrected
Performant	296,703	$453,164,379.53	6,289	$22,422,899.33	302,992	$475,587,278.86
CGI	124,483	$262,620,454.49	4,162	$15,056,413.76	128,645	$277,676,868.25
Connolly	529,969	$771,096,459.96	11,916	$21,338,152.87	541,885	$792,434,612.83
HDI	283,701	$804,330,988.72	15,035	$50,519,579.28	298,736	$854,850,568.00
Unknown[14]	31	$137,773.40	8	$35,045.94	39	$172,819.34
Total	***1,234,887***	***$2,291,350,056.10***	***37,410***	***$109,372,091.18***	***1,272,297***	***$2,400,722,147.28***

[14] These claims could not be attributed to a specific Recovery Auditor.

Appendix D: FY 2012 Medicare FFS Corrections by State

Corrections by State			
State	Overpayments Collected	Underpayments Restored	Total Corrected
AK	$5,059,211.41	$289,475.14	$5,348,686.55
AL	$49,986,606.07	$794,813.66	$50,781,419.73
AR	$29,150,140.94	$273,873.94	$29,424,014.88
AS	$189.63	-	$189.63
AZ	$75,898,966.63	$2,716,305.22	$78,615,271.85
CA	$366,953,649.53	$22,206,906.12	$389,160,555.65
CO	$8,983,678.36	$439,211.03	$9,422,889.39
CT	$42,656,212.65	$931,257.35	$43,587,470.00
DC	$5,129,067.83	$139,215.67	$5,268,283.50
DE	$14,765,661.84	$359,062.79	$15,124,724.63
FL	$124,143,666.23	$4,945,241.03	$129,088,907.26
GA	$62,839,472.87	$1,689,265.76	$64,528,738.63
GU	$60,884.34	-	$60,884.34
HI	$10,796,874.07	$249,861.33	$11,046,735.40
IA	$49,101,852.80	$1,768,277.64	$50,870,130.44
ID	$5,620,184.82	$1,381,361.82	$7,001,546.64
IL	$87,582,029.25	$722,081.20	$88,304,110.45
IN	$25,673,383.14	$450,435.47	$26,123,818.61
KS	$36,666,204.01	$1,181,588.35	$37,847,792.36
KY	$19,168,315.27	$421,111.82	$19,589,427.09
LA	$49,806,448.77	$750,203.23	$50,556,652.00
MA	$32,182,849.00	$5,982,251.26	$38,165,100.26
MD	$25,419,941.56	$306,622.54	$25,726,564.10
ME	$10,041,282.10	$2,962,822.97	$13,004,105.07
MI	$29,692,391.42	$578,723.63	$30,271,115.05
MN	$34,373,996.75	$5,100,500.05	$39,474,496.80
MO	$85,257,709.70	$3,999,055.47	$89,256,765.17
MP[15]	$235.13	-	$235.13
MS	$38,092,755.78	$326,407.26	$38,419,163.04
MT	$16,250,798.65	$421,357.11	$16,672,155.76
NC	$65,441,443.77	$2,741,743.23	$68,183,187.00
ND	$15,458,007.74	$439,656.46	$15,897,664.20
NE	$18,570,185.58	$958,276.37	$19,528,461.95
NH	$4,406,659.45	$1,855,741.80	$6,262,401.25
NJ	$65,081,294.49	$1,733,180.04	$66,814,474.53
NM	$12,239,585.93	$251,131.61	$12,490,717.54
NV	$17,260,943.32	$1,541,035.92	$18,801,979.24
NY	$138,512,415.30	$2,945,898.40	$141,458,313.70

[15] Northern Mariana Islands

Corrections by State			
State	**Overpayments Collected**	**Underpayments Restored**	**Total Corrected Amount**
OH	$36,105,405.01	$613,536.58	$36,718,941.59
OK	$27,248,137.18	$537,072.54	$27,785,209.72
OR	$15,237,909.82	$4,340,734.71	$19,578,644.53
PA	$107,109,847.59	$2,591,195.41	$109,701,043.00
PR	$1,135,538.11	$236,349.17	$1,371,887.28
RI	$3,867,663.15	$1,032,639.85	$4,900,303.00
SC	$46,196,853.13	$1,402,296.02	$47,599,149.15
SD	$13,377,508.45	$297,716.01	$13,675,224.46
TN	$96,054,918.61	$1,731,796.74	$97,786,715.35
TX	$94,592,976.90	$2,301,855.50	$96,894,832.40
UT	$21,884,191.25	$1,176,637.50	$23,060,828.75
VA	$43,826,064.24	$1,930,750.90	$45,756,815.14
VI	$635,366.76	-	$635,366.76
VT	$3,345,194.51	$1,028,478.85	$4,373,673.36
WA	$38,762,070.34	$6,846,860.92	$45,608,931.26
WI	$28,736,102.50	$6,944,884.03	$35,680,986.53
WV	$11,125,400.03	$638,673.68	$11,764,073.71
WY	$7,606,410.64	$206,002.90	$7,812,413.54
Unknown [16]	$16,177,301.75	$1,660,657.18	$17,837,958.93
Total	***$2,291,350,056.10***	***$109,372,091.18***	***$2,400,722,147.28***

[16] These claims could not be attributed to a specific state.

Appendix E: FY 2012 Medicare FFS Corrections by Type of Claim

Corrections by Claim Type						
	Overpayments Collected		Underpayments Restored		Total Corrected	
Claim Type	No. of claims	Amount Collected	No. of Claims	Amounted Restored	No. of Claims	Amount Corrected
Part A	518,154	$2,168,147,554.26	31,529	$108,250,250.38	549,683	$2,276,397,804.64
Part B	460,792	$81,876,342.61	4,440	$1,019,825.14	465,232	$82,896,167.75
DME	255,941	$41,326,159.23	1,441	$102,015.66	257,382	$41,428,174.89
Total	***1,234,887***	***$2,291,350,056.10***	***37,410***	***$109,372,091.18***	***1,272,297***	***$2,400,722,147.28***

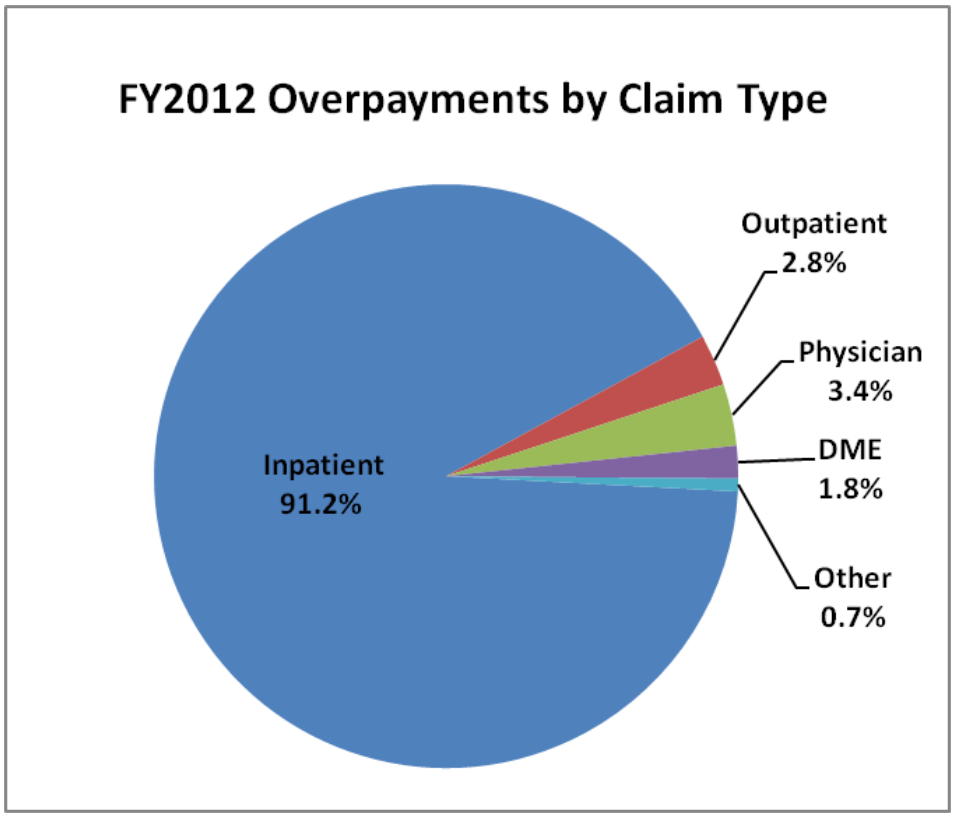
Appendix F: FY 2012 Medicare FFS Corrections by Recovery Auditor and Type of Claim

Corrections by Recovery Auditor and Type of Claim							
		Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	Claim Type	No. of Claims	Amount Collected	No. of Claims	Amount Restored	No. of Claims	Amount Corrected
Performant	A	106,251	$430,733,129.80	5,544	$22,315,892.13	111,795	$453,049,021.93
	B	83,812	$7,659,313.62	562	$45,820.11	84,374	$7,705,133.73
	DME	106,640	$14,771,936.11	183	$61,187.09	106,823	$14,833,123.20
	Subtotal	*296,703*	*$453,164,379.53*	*6,289*	*$22,422,899.33*	*302,992*	*$475,587,278.86*
CGI	A	50,238	$257,907,227.04	2,825	$15,014,143.98	53,063	$272,921,371.02
	B	14,977	$1,336,231.29	107	$11,747.77	15,084	$1,347,979.06
	DME	59,268	$3,376,996.16	1,230	$30,522.01	60,498	$3,407,518.17
	Subtotal	*124,483*	*$262,620,454.49*	*4,162*	*$15,056,413.76*	*128,645*	*$277,676,868.25*
Connolly	A	237,376	$696,864,502.61	10,256	$20,620,018.12	247,632	$717,484,520.73
	B	224,981	$59,210,837.22	1,639	$711,374.98	226,620	$59,922,212.20
	DME	67,612	$15,021,120.13	21	$6,759.77	67,633	$15,027,879.90
	Subtotal	*529,969*	*$771,096,459.96*	*11,916*	*$21,338,152.87*	*541,885*	*$792,434,612.83*
HDI	A	124,258	$782,504,921.41	12,896	$50,265,150.21	137,154	$832,770,071.62
	B	137,022	$13,669,960.48	2,132	$250,882.28	139,154	$13,920,842.76
	DME	22,421	$8,156,106.83	7	$3,546.79	22,428	$8,159,653.62
	Subtotal	*283,701*	*$804,330,988.72*	*15,035*	*$50,519,579.28*	*298,736*	*$854,850,568.00*
Unknown	A	31	$137,773.40	8	$35,045.94	39	$172,819.34
	Subtotal	*31*	*$137,773.40*	*8*	*$35,045.94*	*39*	*$172,819.34*
Total		***1,234,887***	***$2,291,350,056.10***	***37,410***	***$109,372,091.18***	***1,272,297***	***$2,400,722,147.28***

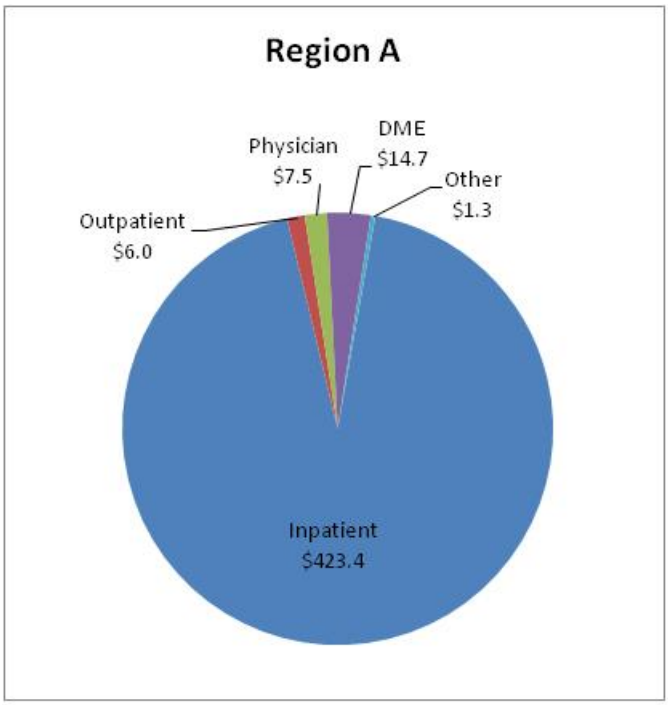
Appendix G1: FY 2012 Medicare FFS Corrections by Claim Type

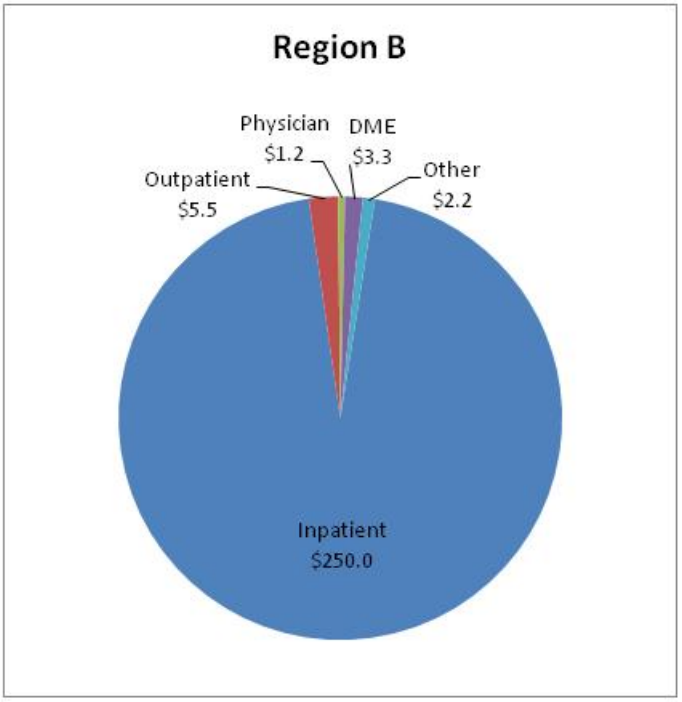
Corrections by Claim Type			
Claim Type	**Overpayments Collected**	**Underpayments Restored**	**Total Amount Corrected**
Inpatient	$2,090,352,301.28	$103,490,848.83	$2,193,843,150.11
Skilled Nursing Facility	$7,975.68	-	$7,975.68
Outpatient	$65,196,748.71	$307,432.41	$65,504,181.12
Home Health	$21,285.51	$3,133,045.86	$3,154,331.37
Physician	$78,296,437.14	$678,112.02	$78,974,549.16
DME	$41,298,006.03	$101,994.88	$41,400,000.91
Other	$16,177,301.75	$1,660,657.18	$17,837,958.93
Total	***$2,291,350,056.10***	***$109,372,091.18***	***$2,400,722,147.28***

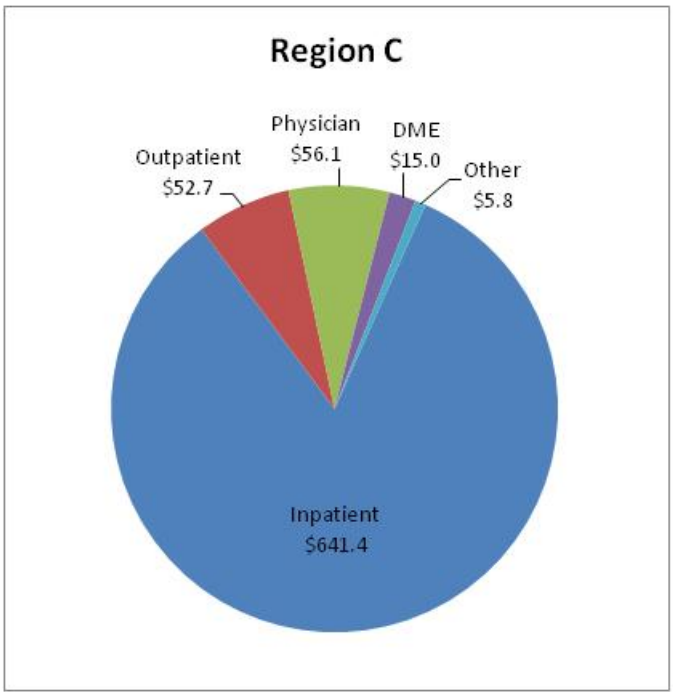
Appendix G2: FY 2012 Medicare FFS Corrections by Claim Type

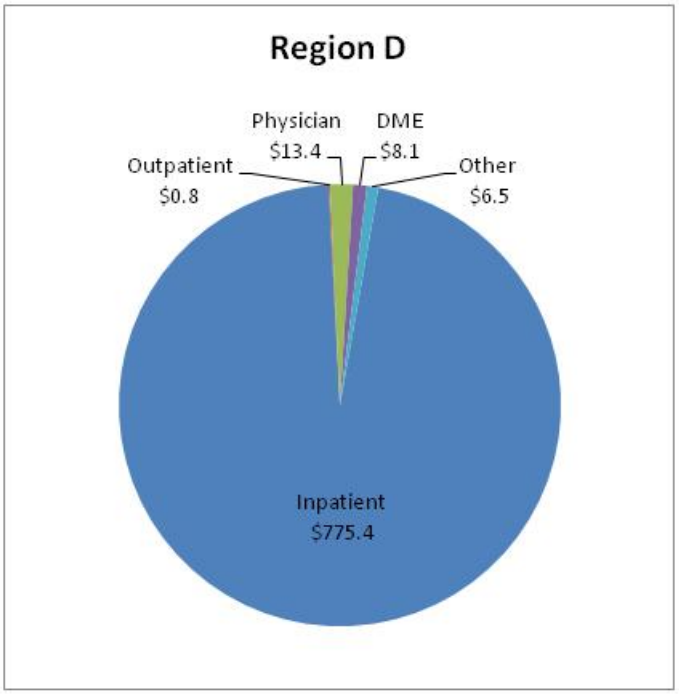


Appendix H: FY 2012 Medicare FFS Overpayments by Claim Type and Recovery Auditor (in millions)





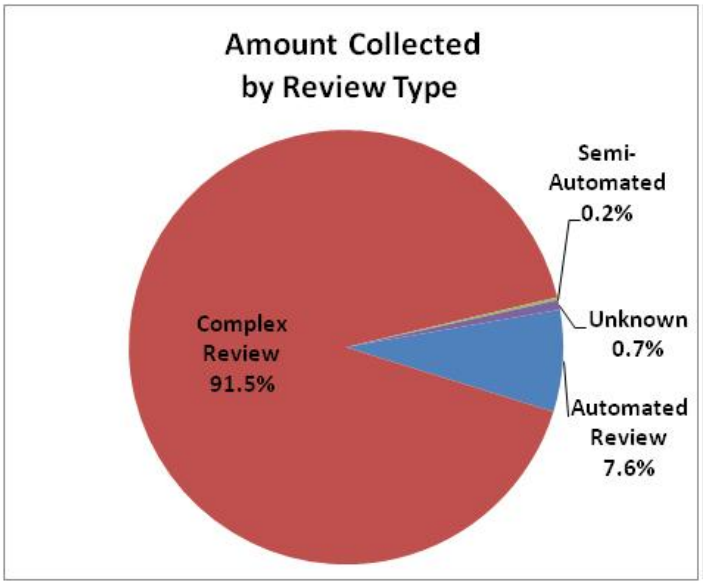


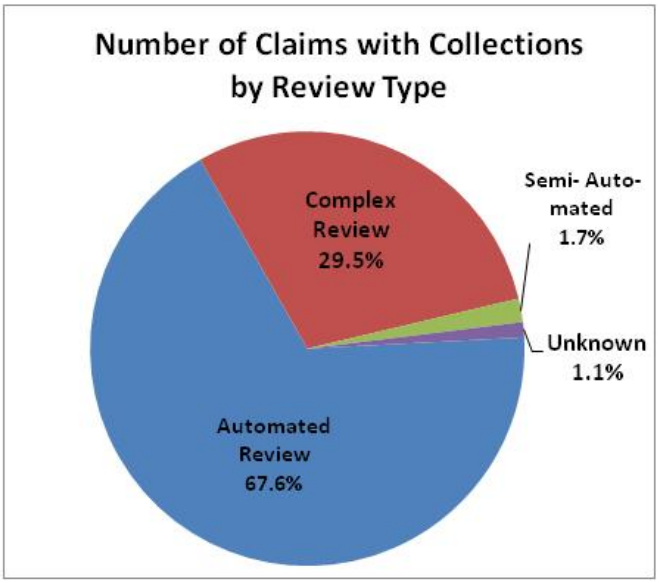


Appendix I1: FY 2012 Medicare FFS Corrections by Review Type

Corrections by Review Type						
	Overpayments Collected		Underpayments Restored		Total Corrected	
Review Type	No. of Claims	Amount Collected	No. of Claims	Amount Restored	No. of Claims	Amount Corrected
Automated	835,128	$173,716,527.16	24,578	$52,330,633.44	859,706	$226,047,160.60
Complex	364,327	$2,096,544,296.68	11,405	$55,369,413.02	375,732	$2,151,913,709.70
Semi-Automated	21,484	$4,911,930.51	74	$11,387.54	21,558	$4,923,318.05
Unknown[17]	13,948	$16,177,301.75	1,353	$1,660,657.18	15,301	$17,837,958.93
Total	***1,234,887***	***$2,291,350,056.10***	***37,410***	***$109,372,091.18***	***1,272,297***	***$2,400,722,147.28***

Appendix I2: FY 2012 Medicare FFS Corrections by Review Type





[17] These claims could not be attributed to a specific review type.

Appendix I3: FY 2012 Medicare FFS Corrections by Review Type and Recovery Auditor

		Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	**Review Type**	**No. of Claims**	**Amount Collected**	**No. of Claims**	**Amount Restored**	**No. of Claims**	**Amount Corrected**
Perfor-mant	Auto	216,946	$28,223,810.91	851	$117,597.70	217,797	$28,341,408.61
	Complex	77,555	$423,545,989.40	5,164	$21,750,769.23	82,719	$445,296,758.63
	Unknown	2,202	$1,394,579.22	274	$554,532.40	2,476	$1,949,111.62
	Subtotal	*296,703*	*$453,164,379.53*	*6,289*	*$22,422,899.33*	*302,992*	*$475,587,278.86*
CGI	Auto	76,243	$8,587,282.41	1,330	$39,264.60	77,573	$8,626,547.01
	Complex	47,228	$251,741,392.02	2,739	$14,787,702.41	49,967	$266,529,094.43
	Semi-Auto	4	$5,405.05	-	-	4	$5,405.05
	Unknown	1,008	$2,286,375.01	93	$229,446.75	1,101	$2,515,821.76
	Subtotal	*124,483*	*$262,620,454.49*	*4,162*	*$15,056,413.76*	*128,645*	*$277,676,868.25*
Connolly	Auto	381,730	$110,608,948.60	10,399	$15,885,903.81	392,129	$126,494,852.41
	Complex	119,787	$650,072,516.02	973	$5,114,898.17	120,760	$655,187,414.19
	Semi-Auto	20,470	$4,595,904.43	68	$7,097.30	20,538	$4,603,001.73
	Unknown	7,982	$5,819,090.91	476	$330,253.59	8,458	$6,149,344.50
	Subtotal	*529,969*	*$771,096,459.96*	*11,916*	*$21,338,152.87*	*541,885*	*$792,434,612.83*
HDI	Auto	160,209	$26,296,485.24	11,998	$36,287,867.33	172,207	$62,584,352.57
	Complex	119,757	$771,184,399.24	2,529	$13,716,043.21	122,286	$784,900,442.45
	Semi-Auto	1,010	$310,621.03	6	$4,290.24	1,016	$314,911.27
	Unknown	2,725	$6,539,483.21	502	$511,378.50	3,227	$7,050,861.71
	Subtotal	*283,701*	*$804,330,988.72*	*15,035*	*$50,519,579.28*	*298,736*	*$854,850,568.00*
Unknown [18]	Unknown	31	$137,773.40	8	$35,045.94	39	$172,819.34
Total		***1,234,887***	***$2,291,350,056.10***	***37,410***	***$109,372,091.18***	***1,272,297***	***$2,400,722,147.28***

[18] These claims could not be attributed to a specific Recovery Auditor or review type.

Appendix J: FY 2012 Medicare FFS Complex Review Improper Payment Identification Rate

Recovery Auditor	Number of ADRs Fulfilled by Providers	Improper Payment Identifications*	Improper Payment Identification Rate
Performant	288,330	64,532	22.4%
CGI	192,465	30,815	16.0%
Connolly	356,672	129,792	36.4%
HDI	266,676	95,548	35.8%
Total/Average	***1,104,143***[19]	***320,687***	***29.0%***

*Identifications include claims with demanded overpayments and underpayments

[19] Providers must send in their medical documentation within 45 days of receiving an ADR from a Recovery Auditor. If the provider doesn't send in the appropriate documentation in this timeframe, the Recovery Auditor will deny the claim.

Appendix K: FY 2012 Cumulative Accuracy Scores by Medicare FFS Recovery Auditor

Cumulative Accuracy Score	
Recovery Auditor	**Accuracy Score**
Performant	96.3%
CGI	96.3%
Connolly	92.5%
HDI	97.2%

Note: In FY 2012, 12 random samples were drawn to determine the accuracy scores. The universe for each region was all claims adjusted by the Recovery Auditor from May 2011 - April 2012. The sample size reviewed for each Recovery Auditor was between 1100 and 1200 claims.

Appendix L: FY 2012 Overall Medicare FFS Appeals by Claim Type

Claim Type	Number of Claims with Overpay-ment Determin-ations	Number of Claims in which Providers Appealed				Claims Appealed by Providers at any Level		Appealed Claims with Decisions in Provider's Favor		Percent of Overpayment Determinations Overturned on Appeal
		MAC	QIC	ALJ	DAB	No. of Claims	Percent of Claims	No. of Claims	Percent of Claims	
A	588,364	177,442	73,278	13,030	56	263,806	44.84%	36,927	13.99%	6.28%
B/DME	830,807	102,136	6,955	329	55	109,475	13.18%	62,565	57.15%	7.53%
Other				1						
Total	***1,419,171****	***279,578***	***80,233***	***13,360***	***111***	***373,282****	***26.30%***	***99,492***	***26.65%***	***7.01%***

*The statistics above include first, second, and third level appeals with decisions in FY 2012. Claims may have overpayment determination dates prior to FY2012.

**It is possible that appeals may be counted multiple times if there were multiple decisions in FY 2012 (i.e. second level appeals may be counted twice, third level appeals may be counted three times).

Source: QIC and DAB appeals data was provided by the Administrative QIC, Q2A Administrators. ALJ appeals data was provided by OMHA. Data included in the "Other" category is from OMHA and is not attributed to a specific Recovery Auditor.

Appendix M:Medicare FFS Recovery Audit Program Informational Resources

Program Resources	
Website	**Information Provided**
CMS.gov/recovery-audit-program	This Recovery Audit Program specific agency website includes background information on the program, Recovery Auditor (and subcontractor) information for each region, the final Statement of Work, appeals information, limitations on recoupment, frequently asked questions, quarterly updates on corrections and identified vulnerabilities, and articles for provider education.
http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf	Contains archived provider compliance articles to help address common billing errors
Recovery Auditor Websites	Contains updated information on audits conducted, approved new issues, as well as sample correspondence and documentation submission instructions. The Recovery Auditor websites are as follows: 1)Region A/Performant Recovery: *performantrac.com* 2)Region B/CGI: *racb.cgi.com* 3)Region C/Connolly: *connolly.com* 4)Region D/HDI: *healthdatainsights.com*