Recovery Auditing in the Medicare and Medicaid Programs for Fiscal Year 2011

FY 2011 Report to Congress as Required by Section 1893(h) of the Social Security Act for Medicare and Section 6411c of the Affordable Care Act for Medicaid

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Executive Summary

Medicare Fee-for-Service Recovery Audit Program

The Medicare Fee-for-Service (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 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 health care providers in accordance with Medicare regulations, and educate providers regarding how to submit accurately coded claims that meet Medicare guidelines.

The CMS uses several contractors to ensure that paid claims are paid based on Medicare guidelines. One of the contractors used is a Recovery Auditor. A Recovery Auditor is a CMS contractor whose primary task is to review Medicare claims data and determine if the claim was appropriately paid. The Tax Relief and Health Care Act of 2006 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 into 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 to CMS common billing errors, trends, and other Medicare payment issues.

In Fiscal Year (FY) 2011, Recovery Auditors collectively identified and corrected 887,291 claims for improper payments, which resulted in $939.3 million dollars in improper payments being corrected. The total corrections identified include $797.4 million in overpayments and $141.9 million in underpayments repaid to providers and suppliers (see Appendix B). After taking into consideration all fees, costs, and appeals the Medicare FFS Recovery Audit Program returned $488.2 million to the Medicare Trust Fund.

The CMS uses the results of audits performed by the Recovery Auditors to identify potential vulnerabilities and take appropriate corrective actions to prevent future improper payments. 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 edits, and additional review by other entities.

The CMS continues to make improvements to the Recovery Audit Program. In FY 2011, CMS launched the esMD system to facilitate the transmission of electronic medical records and all Recovery Auditors are working toward using this. This enhancement permits providers to send medical documentation electronically to contractors upon request and helps eliminate the costly and time-consuming need for providers and suppliers to send tangible records for contractor review. 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 and supplier education, as it presents a forum for discussion, and it can identify

erroneous billing practices to the provider about policies that need clarification. CMS also is focusing on collaborating more with the MACs and meeting regularly to discuss potential improvements.

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

Implementation of Recovery Audit Contracting in Medicare Advantage, Medicare Prescription Drug and Medicaid Programs

Section 6411(b) of the Affordable Care Act (ACA) expanded the use of recovery audit contractors (RAC) to Medicare Parts C and D. CMS has initiated implementation of Part C and Part D RACs. A contract for Part D recovery auditing was awarded on January 13, 2011 to ACLR Strategic Business Solutions. ACLR's initial review focused on identifying improper payments for prescriptions written by excluded prescribers or filled by excluded pharmacies. Recoupment began in the first quarter of FY 2013 for those plans that did not appeal findings identified in the RAC's initial audit review. In addition to the Part D RAC procurement activity, CMS solicited comments on how best to implement the Medicare Part C recovery auditing program through a Request for Information (RFI) that was published in the *Federal Register* on December 27, 2010[1]. Analysis of the comments received will assist CMS with implementation of a Part C RAC.

Section 6411(a) of the Affordable Care Act amended section 1902(a)-(42) of the Social Security Act to require that States and territories establish RAC programs. States must contract with one or more RACs in their Medicaid programs and are expected to administer their Medicaid RAC programs within the Federal regulatory framework established by CMS. CMS published a Notice of Proposed Rule Making (NPRM) for the establishment of Medicaid RACs on November 10, 2010. The Final rule was published on September 16, 2011. It requires states to implement their Medicaid RAC programs, absent an exception, by January 1, 2012. At the conclusion of FY 2011, states have made progress in implementing their Medicaid RAC programs, including several states that have Medicaid RAC contracts in place and many others that are in the procurement process.

[1] Medicare Program: Solicitation of Comments Regarding Development of a Recovery Audit Contractor Program for the Medicare Part C and D Programs. http://www.gpo.gov/fdsys/pkg/FR-2010-12-27/pdf/2010-32498.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 error 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.[2]

As part of its efforts to implement the IPIA, the CMS uses the Comprehensive Error Rate Testing (CERT) program to identify areas that may be vulnerable for improper payments in Medicare FFS. CMS uses these results to direct future work by the 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 based on claim types and/or vulnerabilities that have been identified in each MAC jurisdiction and are targeted to potential claims that based on data analysis may be improper. Additional provider education, widespread or localized, could also be 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 another 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. 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

While all claims submitted to Medicare are screened by thousands of system edits prior to payment, claims are generally paid without requesting the supporting medical records. As a result, some claims may be paid inappropriately, resulting in improper payments.

Payments may be improper for many reasons but the most prevalent are:

[2] Additional information about the Medicare Fee-for-Service national error rate can be found at www.cms.gov/cert.

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

Most improper payments can only be identified through review of the medical record. Given the volume of claims submitted to CMS on a daily basis, CMS is not able to perform 100 percent medical review prior to payment, commonly referred to as pre-payment review. CMS must rely on conducting medical record review after payment, commonly referred to as post-payment review.

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. 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.

The Tax Relief and Health care Act (TRHCA) of 2006 (P.L. 109-432) authorized the Recovery Audit program expansion nationwide by January 2010 (see Appendix A). The TRHCA 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. This report satisfies that requirement as well as the requirement in The Patient Protection and Affordable Care Act (P.L. 111-148) that requires an annual report to Congress concerning the effectiveness of the Recovery Audit program under Medicaid and Medicare.

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. CMS established the 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 post-payment review.

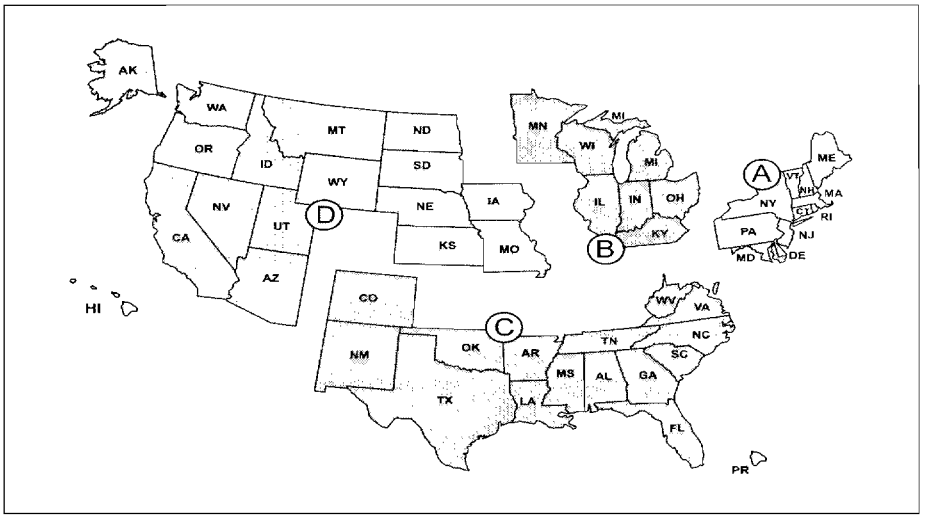
The Recovery Auditors in each region in FY 2011 were:

- Region A: Diversified Collection Services (DCS)
- Region B: CGI
- Region C: Connolly

- Region D: HealthData Insights (HDI)

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

Figure 1:



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 and is negotiated with the Recovery Auditors at the time of the contract award. The base contingency fees ranged from 9.0-12.5 percent for all claim types except DME. The contingency fees for DME claims ranged from 14.0 percent—17.5 percent. The Recovery Auditor must return the fee if an improper payment is overturned at any level of appeal.

Recovery Audit Review Process

The Recovery Auditors actively review Medicare FFS claims on a post-payment basis. CMS limited claims eligible for review to those falling within a three year look-back timeframe. Recovery Auditors use the same identification and recoupment process as other Medicare contractors. Recovery Auditors follow all regulations and policies regarding the coverage and payment of claims when making review determinations. The Recovery Audit process begins with identification and ends with recoupment and/or an appeal by the provider. To identify and correct improper payments, the following process occurs:

Review:

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 made through data analysis. However, these reviews account for instances when provider documentation may substantiate the claim, and allow the provider to supply the supporting documents.
- **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.

In FY 2011, CMS introduced semi-automated reviews to avoid unnecessary administrative costs associated with appeal. Semi-automated reviews are unique from automated, as they allow the provider to see the initial claim determination, and if possible, provide supporting claim documentation. This process allows for greater provider-contractor communication. This process does not demand documentation be rendered, and the provider may decide what information, if any, should be provided to support the payment. CMS also expanded complex reviews such as reviewing inpatient claims to determine if the services provided in an inpatient setting were medically necessary.

Demand:

After an improper payment is identified, the next step in the process is notifying the provider of the overpayment or underpayment. In the case of an underpayment, the provider is notified via letter of 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 how to proceed for additional adjudication or appeal.

Recovery Auditors are also required to give a detailed review rationale in their review results letters, indicating why improper payments have been determined for those claims that underwent a complex review. These letters include references utilized in reviewing the medical documents, and they educate providers about how to avoid similar payment errors in future Medicare billing practices.

In FY 2011, CMS also transitioned the responsibility of sending demand letters from the Recovery Auditor to the MAC to streamline contractor correspondence and ensure timeliness of demand notifications. Although this change was fully operational in January 2012, CMS began the transition in FY 2011. Previously, the Recovery Auditors sent the demand letters after receiving confirmation of the claim adjustments from the MACs. After discussing best practices for future implementation with major provider associations, CMS decided that this communication should be sent from the MAC using automated means. This will streamline Recovery Audit program correspondence with all other claim processing contractor-provider correspondence and allows for quicker delivery of demand letters.

Appeals:

The administrative appeals process is multilevel, which allows providers to appeal an improper payment determination. This process is exactly the same for all providers who want to appeal a Medicare claim decision. The levels of appeal are described below.

Redetermination:

Performed by the claim processing contractor, 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. Again, the QICs have 60 days to process.

Administrative Law Judge (ALJ):

This level of appeal includes a minimum amount in controversy (currently $130), and must be filed within 60 days of the reconsideration notice. The claim must be processed within 90 days of receipt. This level allows a hearing, and thus more party involvement and explanation.

Appeals Council Review:

This level may be requested following an unfavorable ALJ decision. It must be filed within 60 days of the ALJ decision, and must be processed within 90 days of request.

Final Judicial Review (Federal District Court Review):

The current minimum amount in controversy is $1,300. This appeal must be filed within 60 days of the appeals council notice, but the Federal Court does not have a deadline for their review.

Collection and Repayment:

Collection efforts for overpayments and repayments of underpayments are handled by the MACs. The recoupment of an overpayment may be offset against future payments made by the claims processing contractor if payment is not received within the specified timeframe. The provider may also apply for an extended repayment plan. Typically, recoupment from future repayments begins 41 days after the adjustment/date of the demand letter. In addition, the receipt of a valid appeal may also delay

recoupment. Underpayments are paid back to the provider by the claims processing contractor.

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, communicating 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 issues 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 which is comprised of CMS policy and coverage staff and clinicians. This ensures that policy and coverage staff approves the audit methodology used by the Recovery Auditors and that the correct interpretation of CMS policies is used in the audits. For others, such as automated, semi-automated, and complex coding reviews, CMS uses a contractor to review new issues for potential audits and make recommendations to CMS regarding approval. To further ensure the accuracy of these reviews, CMS is beginning to include the MACs into the review process. This will ensure that the contractor that implemented the policy is aware of the audit and that the Recovery Auditors are correctly interpreting the policies.

Recovery Auditors are also required to have at least one full time Contractor Medical Director (CMD) on staff. The use of CMDs has proven to be a valuable addition to the program, as they provide clinical expertise on and oversight of the medical review process. The CMD is required to be involved in all phases of the new issue, medical review, and quality assurance processes to ensure that policies are being followed and accurate review decisions are being made. The CMD 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 allow for provider education. Some Recovery Auditors have added an additional CMD to provide greater clinical guidance and assistance to staff, providers, and CMS.

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. CMS provides several contractor opportunities for discussion to address any ongoing operational issues and concerns that may impede program efficiency. 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 RAC Data Warehouse to track greater audit detail and information. The RAC Data Warehouse was developed to serve as the primary source of data for the Medicare FFS Recovery Audit Program. CMS continues to improve the RAC Data Warehouse

functionalities to allow more data storage and collection and automating the process of data collection as much as possible.

The CMS has also implemented an Electronic Submission of Medical Documents (esMD) communication system pilot, which began on September 15, 2011. This enhancement permits providers to send medical documentation electronically to contractors upon request. In an increasingly electronic medical record environment, this will eliminate the costly and time-consuming need for providers to send tangible records for contractor review. Two Recovery Auditors began accepting electronic documentation in September 2011, with the others participating in early 2012.

Maximizing Transparency

In order to promote transparency, CMS posts improper payment corrections information, including overpayments and underpayments, on a quarterly basis on its website.[3] CMS also posted the Recovery Auditor statement of work and several educational articles aimed at preventing future improper payments on its website.[4] . The individual Recovery Auditor websites contain all of the new audit issues approved for review, and more recently, search functions have been added to improve the ease of provider navigation.

Recovery Auditors are also required to use web portals to allow providers to review claim information and track the progress of their audits. Recovery Auditors are encouraged to expand their use of the portal to include demand letter information and review rationales. Two Recovery Auditors currently use the portals to give providers detailed review rationale for automated reviews. The portal is used instead of another letter being sent to the provider. This ensures timely receipt of the information by the provider. Some Recovery Auditors also use the portal to deliver messages to the provider communities in their region about specific audits. This includes details about an audit that may have been stopped, discussion period instructions, or 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 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 also imposed additional documentation requests limits on the number of medical records a Recovery Auditor may request in a 45 day timeframe. 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. The limits establish continuity and ensure a provider knows the maximum number of requests that may be received. EsMD offers another alternative for providers to safely and efficiently

[3] This information is posted at www.cms.gov/recovery-audit-program.
[4] This information is posted at www.cms.gov/recovery-audit-program.

transport the documentation. CMS understands that additional staffing is often required to address Recovery Auditor documentation requests and it is constantly working to ensure providers can respond to requests without impacting beneficiary care.

Each Recovery Auditor has a customer service center with representatives available to address provider concerns. The Recovery Audit customer service personnel are required to respond to telephonic, written, or electronic inquiries within specified timeframes. The MACs are also available to address any Recovery Audit program recoupment questions.

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. In addition, CMS works to ensure that multiple review entities such as Recovery Auditors, MACs, and ZPICs are not reviewing the same providers and the same issues at the same time.

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 issues identified and suggestions for their prevention, as well as system edits for errors that can be automatically prevented at the onset. These articles and 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 Trust Fund. These discussions help to ensure uniformity in policy application, and discuss methods for correction and future Trust Fund protection. CMS and other contractors use these calls to discuss future corrective actions, whether local edits and/or education can be effective, or if national edits/education is needed by CMS.

Also, 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.

FY 2011 Results

Overview

In FY 2011, the Recovery Auditors identified and corrected $939.3 million in improper payments. There were $797.4 million collected overpayments and $141.9 million identified underpayments that have been paid back to providers (see Appendix B).

The CMS spent $129.4 million to operate the Medicare FFS Recovery Audit Program, of which $81.9 million were contingency fees paid to Recovery Auditors. Administrative costs such as processing appeals, cost of adjusting claims, support contractors, and oversight of the program accounted for the additional $47.5 million. After taking into consideration all costs, underpayment determinations *that are paid to providers,* and appeal reversals, the Medicare FFS Recovery Audit Program returned $488.2 million to the Medicare Trust Funds in FY 2011 (see Appendix J).

FY 2011 marked the first year that Recovery Auditors actively reviewed short-stay inpatient hospital admission issues. Some short-stay inpatient hospital services should have been provided in the outpatient setting and they fail to demonstrate medical necessity for the inpatient setting. These admissions represent a significant portion of Medicare's FFS error rate and also represent a large portion of the FY 2011 overpayment collections.

The CMS also uses a validation contractor to review a monthly random sample of claims to determine the accuracy of the Recovery Auditors' results. The validation contractor selects a sample of claims that each Recovery Auditor has reviewed, determines their agreement or disagreement with the findings documented, and establishes an accuracy score for each Recovery Auditor. The validation contractor 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 2011, all Recovery Auditors had a cumulative accuracy score of 90 percent or higher (see Appendix H).

Appeals

The CMS has received fairly successful feedback from an appeals perspective. In FY 2011, only 2.9 percent of all Recovery Auditor determinations have been challenged and later overturned on appeal (see Appendix I). Medicare providers appealed 60,717 claims, which constitute 6.7 percent of all claims with overpayment determinations. Of those claims appealed, 26,469 claims were overturned (43.6 percent).

Appeals are overturned for a variety of reasons. The most prevalent reasons are:

- Different interpretation of policy by the Recovery Auditor and the review entity, or
- The claim was incorrect when billed but was corrected on appeal (such as adding a modifier or correcting the number of units).

The receipt of appeals and the reversal of a Recovery Auditor decision do not necessarily mean the Recovery Auditor was incorrect in its determination. Automated reviews which have a reversal rate of approximately 59 percent are often correct as denied. However, the provider can correct the claim during

the appeals process by adding a modifier, correcting the number of units, or modifying the claim so that it follows CMS policy for payment. In these cases, the Recovery Auditor was correct in its denial. CMS believes these should be reported as a separate category and therefore made changes late in calendar year 2011 to provide more detail for reporting purposes. In other cases, the Recovery Auditor was incorrect in its interpretation of the policy. When possible, CMS identifies these areas in advance so that the burden of the appeals process can be avoided by the provider.

CMS has made recent changes to the new issue approval process to decrease the amount of errors made by the Recovery Auditors. Complex reviews have an appeal overturn rate of 20 percent. This is usually a difference in clinical opinions regarding the denial and/or the interpretation of the policy. The Recovery Auditors and the MACs work together to help the Recovery Auditor better understand and interpret the policy in the jurisdictions which will help to decrease the appeal overturn rate at the first level. CMS strives to lower the appeal rate to decrease provider burden and administrative costs. Recovery Auditors also increased their collaboration with the MACs to determine the validity of reviews and the implementation of semi-automated reviews designed to allow providers to share information prior to an adjustment.

FY 2011 saw an increased amount of participation by Recovery Auditors at the ALJ appeal level. Appeals involvement by Recovery Auditors aids in contractor and provider education, as it presents an additional forum for discussion beyond [the initial level of determination?], and can identify erroneous billing practices to the provider or 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.

Corrective Actions

Development of corrective actions to prevent improper payments is a continually improving process at CMS and it is an agency-wide collaborative effort. The CMS holds weekly meetings between CMS, MACs, Recovery Auditors, and Validation Contractor staff. Contractors introduce the issue and their review strategy, and open up the discussion for policy implications and/or clinical judgment variations. These sessions create a forum for contractors to share productive areas of review, and all contractors are required to include the applicable CMS policies and their suggestions for corrective action. These calls also provide the opportunity for discussions regarding future corrective actions ranging from CMS articles, local and national edits, possible regulation and program guidance and additional review by other entities.

The inclusion of MACs in the weekly meetings also allows for CMS to explore methods of automated correction. If the vulnerability may be addressed through a payment system edit, the contractor will work to implement it as quickly as possible. These edits will either flag the claim for future review, or as needed, disallow payment entirely. To date, three national edits have been put into effect. Since different regions may have differing local coverage policies, edits may not always be applicable in multiple jurisdictions.

Periodically, CMS staff has determined that in addition to CMS education, clarifying the *Coding Clinic*© guidelines could result in more accurate coding practice. In such instances, CMS has reached out to the American Hospital Association to either clarify or update coding guidance.

Every quarter, CMS posts the top audit issue for each region on the CMS Recovery Audit Program website. This posting provides important information to providers on areas of potential vulnerability. These postings, along with the posted new issues, give providers information to conduct their own internal reviews. Internal reviews by a provider's internal compliance program are a valuable resource to ensure providers are billing accurately. The top issues per region can be found in Appendix G.

In FY 2011 CMS conducted 55 Major Finding calls with CMS and MAC staff to discuss Recovery Auditor vulnerabilities. These calls included discussions on 43 Part A issues, 7 Part B issues typically involving physician claims and 5 DME issues typically involving supplier claims. CMS also began discussions with system maintainers to install system edits for the automated issues identified by the Recovery Auditors. These changes are substantial and will take some time to implement in the system. CMS also continued work on a vulnerability system which when complete will include all vulnerabilities as well as corrective actions completed.

CMS published four Provider Compliance Newsletters, discussing a total of 31 identified vulnerabilities.[5] The CMS received positive feedback from provider associations regarding the value of these documents, and plans to continue their issuance. The CMS staff also issues MLN Matters articles based on Major Findings and subsequent discussions for provider review. In this fiscal year, the program has resulted in the publication of three such educational articles: *Recovery Audit Program Diagnosis Related Group (DRG) Coding Vulnerabilities for Inpatient Hospitals* (SE1121), *Recovery Audit Contractor (RAC)*

[5] These publications are available at: http://www.cms.gov/MLNProducts/downloads/MedQtrlyCompNL_Archive.pdf.

Demonstration High-Risk Vulnerabilities for Physicians (SE1036) and *Guidance on Hospital Inpatient Admission Decisions* (SE 1037).[6]

[6] The first and third articles are available at: http:www.cms.gov/regulations-and-guidance/guidance/transmittals/2011-transmittals.html. The second article is available at: http://www.cms.gov/regulations-and-guidance/guidance/transmittals/2010-transmittals.html.

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.

1) In 2011, CMS launched the esMD system for paperless transmission of electronic medical records. All of the Recovery Auditors are striving to adopt this system, and future releases may also allow for expanded paperless correspondence. This change in process will promote efficiency and organization, while eliminating time consuming and costly historical methods. By keeping electronic medical records, this process also helps guarantee the record will be passed throughout the varying levels of the appeals process.

2) The CMS recently instituted an opportunity for the Recovery Auditors and claims processing contractors to meet annually and discuss program issues and potential improvements. 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 issues are not being reviewed by more than one Medicare fee-for-service entity to further reduce provider and supplier burden.

3) 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. At times, CMS also refers issues to the Recovery Auditor. Most often, these referrals are from the Office of Inspector General reports.

Program Expansion

As part of CMS's comprehensive plan to reduce the improper payment rate, CMS is exploring several options to expand the Recovery Audit Program. In the FY 2013 President's Budget, CMS included a legislative proposal to retain a portion of Recovery Audit recoveries to implement actions that prevent fraud and abuse.

The CMS has also requested approval to conduct a demonstration program allowing Recovery Auditors to conduct prepayment review. This demonstration request would be limited to (11) states and would begin with short stay inpatient claims. The demonstration will give CMS the opportunity to see if the Recovery Audit Program can be successful in conducting prepayment review and if the added review will help in lowering the error rate.

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

The Affordable Care Act expanded RACs to the Medicare Advantage (Part C) and the Medicare Prescription Drug (Part D) programs, as well as to State Medicaid programs. Below is information about the authority and status of these efforts.

Medicare Parts C and D

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 plans in reconciled Medicare claims 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. Preliminary work by the RAC was performed throughout 2011, and an announcement of the Part D RAC program was sent to the Part C and Part D plans on May 31, 2011. On September 30, 2011, CMS also awarded a contract for a Data Validation Contract (DVC) to provide a validity check to the Part D RAC's work. 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.[7] This page includes a description of the RAC's authority and functions, the audit issues intended for review as well as the procedures for review. CMS is currently developing additional forums where Parts C and D plans and the public can obtain Part D RAC information. The Part D RAC has determined priority areas for review including payments for prescriptions written by excluded prescribers or filled by excluded pharmacies. Overpayment recoupment will be suspended for any plan that submits an appeal. For those plans who do not appeal, recoupment is expected to begin in mid FY 2013. In addition to the Part D RAC procurement activity, CMS solicited comments on how best to implement the Medicare Part C recovery auditing program through a Request for Information (RFI) that was published in the Federal Register on December 27, 2010[8]. Analysis of the comments received will assist CMS with implementation of a Part C RAC. After analysis of the comments CMS will determine if additional information is needed. CMS anticipates awarding a Part C RAC contract in Summer 2013.

Medicaid RACs

Section 6411(a) of the Affordable Care Act amended section 1902(a)-(42) of the Social Security Act (the Act) to require that States and territories establish RAC programs. In addition, the Act requires States and their Medicaid RACs to coordinate their recovery audit efforts with other contractors or entities performing audits of entities receiving Medicaid payments, as well as Federal and State law enforcement agencies, including the Department of Justice (DOJ), , the Inspector General of the Department of Health and Human Services, and the State Medicaid Fraud Control Units (MFCU). States must contract with one or more RACs in their Medicaid programs and are expected to administer their Medicaid RAC programs within the Federal regulatory framework established by CMS. CMS published a Notice of Proposed Rule Making (NPRM) for

[7] Part D RAC informational page available at: http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/recovery-audit-program-parts-c-and-d/Part-D-Recovery-Audit-Contractor.html

[8] Medicare Program: Solicitation of Comments Regarding Development of a Recovery Audit Contractor Program for the Medicare Part C and D Programs. http://www.gpo.gov/fdsys/pkg/FR-2010-12-27/pdf/2010-32498.pdf.

the establishment of Medicaid RACs on November 10, 2010. Based upon numerous public comments, CMS determined that many aspects of the Medicaid RAC program should operate in alignment with the Medicare fee-for-service Recovery Audit program for Parts A and B. The Final rule, which reflects this alignment, was published on September 16, 2011 and required States to implement their Medicaid RAC programs, absent an exception, by January 1, 2012.[9]

The expansion of the RAC program to Medicaid is part of a significant initiative to reduce waste and improper payments to Medicaid providers. Key provisions of the Final rule include the following:

- States must coordinate the recovery auditing efforts of their Medicaid RACs with other auditing entities.
- States must set limits on the number and frequency of medical records to be reviewed by Medicaid RACs subject to requests for exceptions made by the RACs.
- States must make referrals of suspected fraud and/or abuse to law enforcement.
- States must notify providers of underpayments that are identified by the Medicaid RACs.
- States may exclude Medicaid managed care claims from review by Medicaid RACs.
- RACs must hire a minimum of 1.0 FTE Contractor Medical Director who is a Doctor of Medicine or Doctor of Osteopathy in good standing with the relevant state licensing authorities and has relevant work and educational experience, unless the state receives an exception.
- RACs must hire certified coders unless the state determines that certified coders are not required for the effective review of Medicaid claims.
- RACs must work with the state to develop an education and outreach program.
- RACs must provide certain minimum customer service measures.
- RACs must not review claims that are older than three years from the date of the claim, unless they receive approval from the state.
- RACs should not audit claims that have already been audited or are currently being audited by another entity. Lastly,
- If a provider appeals a Medicaid RAC overpayment determination and the determination is reversed, at any level, then the Medicaid RAC must return its contingency fee within a reasonable timeframe.

In 2011, CMS offered several forums to provide technical assistance and support to states to assist in implementation of their Medicaid RAC programs. These activities included:

- "All State Calls" on program guidance after the release of the Final rule;
- Presentations regarding lessons learned from the Medicare Recovery Audit Program;
- A training session on RAC Financial Reporting on the CMS-64 for state financial staff (offered at the Medicaid Integrity Institute, Columbia, South Carolina);
- Webinar on RAC Financial Reporting on the CMS-64 for state Program Integrity Directors;
- Presentations regarding RAC Fraud Referrals to state Medicaid Agencies;
- Presentations on RAC Program Reporting Metrics; and the

[9] 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.

- Launch of CMS website entitled "Medicaid RACs-At-A-Glance."[10]

On February 17, 2011, CMS launched the "Medicaid RACs At-A-Glance" website, which currently provides basic information on states' Medicaid RAC State Plan Amendments (SPAs) to establish RAC programs, along with any exception requests that were submitted by states. The webpage also offers a "submit feedback" function which enables users to submit questions to CMS about Medicaid RACs. During FY 2011, CMS received and responded to 17 inquiries via the Medicaid RACs At-A-Glance website. CMS laid the groundwork for the next phase of the RACs At-A-Glance which will include a web portal that states will use to submit descriptive information to CMS regarding their RAC programs including the name of the state's RAC vendor(s) and the payment methodology. A third phase of the portal is planned for late FY 2012. It will collect performance metrics on each state's RAC program, discussed below.

The Medicaid RAC Final rule requires states to report on certain performance metrics to CMS. During FY 2011, CMS sought state feedback in developing these metrics, including input from its Medicaid Fraud and Abuse Technical Advisory Group. States will use these metrics to report their initial FY 2012 performance data to CMS at the conclusion of that fiscal year. The performance metrics gather information on the number of audits completed, overpayments identified and recovered, underpayments identified, and fraud referrals to MFCUs.

At the conclusion of FY 2011, states have made progress in implementing their Medicaid RAC programs. Several states had Medicaid RAC contracts in place and many others had released requests for proposals. Some states reported that they were awaiting the guidance of the Final rule prior to finalizing procurement actions. A few states contacted CMS requesting exceptions to the January 1, 2012 implementation date and other programmatic requirements. An exception, authorized by section 6411(a) of the Affordable Care Act, is any variation of the requirements in the Final rule, and is accomplished by a state submitting a State Plan Amendment (SPA) to CMS, along with documented reasons in support of its request. CMS can approve the request contained in the SPA, deny it or work with the state to craft a compromise which would then be resubmitted to CMS. In FY 2011, CMS granted five territories complete exemptions from establishing RAC programs. Territories received exemptions because they did not have the Medicaid claims data infrastructure to support a RAC program. In considering exception requests from states, CMS reviews the justifications submitted by the states in support of their requests. For example, South Dakota was granted a time-limited exception from implementing a Medicaid RAC program until May 31, 2013. CMS considered factors such as the state's small Medicaid beneficiary population claims volume and associated expenditures, low error rate in Medicaid payments, and already existing successful Medicaid integrity efforts, in deciding whether to approve a temporary implementation exception for that state. CMS anticipates providing a more abundant report on state implementation and outcomes in future reports to Congress.

[10] CMS website entitled "Medicaid RACs-At-A-Glance is available at: http://w2.dehpg.net/RACSS/Map.aspx.

Appendices

A. Applicable Laws

- A1. Tax Relief and Health Care Act of 2006 (Section 302)
- A.2. Affordable Care Act (Section 6411)

B. Corrections by Recovery Auditor

C. Corrections by State

D. Corrections by Types of Claim (table)

E. Corrections by Recovery Auditor and Type of Claim (table)

F. Corrections by Claim Type

- F1. Corrections by Claim Type (table)
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G. Top Issues by Recovery Auditor

- G1. Top Issues by Recovery Auditor— Overpayments
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H. Cumulative Accuracy Scores

I. Appeals by Recovery Auditor

- I1. Appeals Breakdown by Recovery Auditor, Type of Claim, & Level
- I2. Appealed and Overturned Claims
- I3. Appealed and overturned Claims—Type of Review

J. Amount Returned to the Medicare Trust Fund

K. Recovery Audit Program Informational Resources

NOTE: Appendices B-K include figures relevant to the Medicare FFS Recovery Audit program only.

Appendix A1:

Tax Relief and Health Care Act of 2006

SEC. 302. EXTENSION AND EXPANSION OF RECOVERY AUDIT CONTRACTOR PROGRAM UNDER THE MEDICARE INTEGRITY PROGRAM.

(a) In General- Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

(h) 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 part A or B. 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 parts A and B.

(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.

(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 part A or B--

(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 an 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.'.

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: FY 2011 Corrections by Recovery Auditor

Corrections by Recovery Auditor						
	Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	*No. of Claims*	*Collected Overpayments*	*No. of Claims*	*Restored Underpayments*	*No. of Claims*	*Total Corrected Amount*
A / DCS	97,929	$ 127,806,524.55	9,981	$ 18,458,974.74	107,910	$ 146,265,499.29
B / CGI	86,215	$ 160,326,687.27	3,454	$ 10,035,411.13	89,669	$ 170,362,098.40
C / Connolly	259,124	$ 191,304,793.37	23,635	$ 69,646,529.59	282,759	$ 260,951,322.96
D / HDI	383,462	$ 318,009,022.18	23,491	$ 43,777,126.15	406,953	$ 361,786,148.33
Total	***826,730***	***$ 797,447,027.37***	***60,561***	***$ 141,918,041.61***	***887,291***	***$ 939,365,068.98***

Appendix C: FY 2011 Corrections by State

Corrections by State			
State	Collected Overpayments	Restored Underpayments	Total Corrected Amount
AK	$ 1,223,935.82	$ 79,764.97	$ 1,303,700.79
AL	$ 12,538,871.13	$ 2,081,731.54	$ 14,620,602.67
AR	$ 7,330,720.72	$ 3,159,152.97	$ 10,489,873.69
AS	$ 117.06	-	$ 117.06
AZ	$ 28,277,971.79	$ 2,075,651.96	$ 30,353,623.75
CA	$ 143,133,738.79	$ 25,385,403.43	$ 168,519,142.22
CO	$ 2,190,244.96	$ 596,984.34	$ 2,787,229.30
CT	$ 19,023,209.31	$ 1,363,207.92	$ 20,386,417.23
DC	$ 994,753.11	$ 64,450.23	$ 1,059,203.34
DE	$ 4,776,155.43	$ 351,239.55	$ 5,127,394.98
FL	$ 32,423,201.18	$ 8,437,244.44	$ 40,860,445.62
GA	$ 17,242,772.68	$ 3,397,036.90	$ 20,639,809.58
GU	$ 13,052.36	$ (143.53)	$ 12,908.83
HI	$ 4,464,650.05	$ 319,533.50	$ 4,784,183.55
IA	$ 12,842,581.74	$ 666,809.42	$ 13,509,391.16
ID	$ 1,710,179.49	$ 870,460.76	$ 2,580,640.25
IL	$ 43,026,477.63	$ 807,927.23	$ 43,834,404.86
IN	$ 28,317,623.74	$ 524,980.38	$ 28,842,604.12
KS	$ 9,390,156.45	$ 509,574.87	$ 9,899,731.32
KY	$ 10,647,664.77	$ 284,218.13	$ 10,931,882.90
LA	$ 12,810,032.96	$ 4,903,865.45	$ 17,713,898.41
MA	$ 7,645,274.29	$ 2,767,479.79	$ 10,412,754.08
MD	$ 634,273.25	$ 63,675.39	$ 697,948.64
ME	$ 2,575,241.16	$ 1,836,523.50	$ 4,411,764.66
MI	$ 39,173,513.44	$ 577,616.29	$ 39,751,129.73
MN	$ 5,939,016.63	$ 3,239,341.84	$ 9,178,358.47
MO	$ 31,358,569.68	$ 400,194.91	$ 31,758,764.59
MP	$ 76.74	-	$ 76.74
MS	$ 9,524,772.73	$ 4,667,025.00	$ 14,191,797.73
MT	$ 8,967,839.91	$ 489,606.78	$ 9,457,446.69
NC	$ 11,271,648.96	$ 6,871,499.08	$ 18,143,148.04
ND	$ 10,112,284.98	$ 361,053.99	$ 10,473,338.97
NE	$ 7,049,523.50	$ 269,558.91	$ 7,319,082.41
NH	$ 844,616.55	$ 574,159.97	$ 1,418,776.52
NJ	$ 21,070,689.48	$ 2,356,155.89	$ 23,426,845.37
NM	$ 3,571,064.67	$ 780,514.95	$ 4,351,579.62
NV	$ 7,608,227.83	$ 1,374,112.30	$ 8,982,340.13
NY	$ 44,574,936.10	$ 4,824,629.28	$ 49,399,565.38
OH	$ 24,357,464.54	$ 659,928.64	$ 25,017,393.18

Corrections by State			
State	Collected Overpayments	Restored Underpayments	Total Corrected Amount
OK	$ 7,322,228.47	$ 1,495,427.22	$ 8,817,655.69
OR	$ 4,734,262.92	$ 3,331,852.72	$ 8,066,115.64
PA	$ 22,387,532.78	$ 2,586,002.04	$ 24,973,534.82
PR	$ 155,656.60	$ 117,379.60	$ 273,036.20
RI	$ 1,476,528.48	$ 486,464.63	$ 1,962,993.11
SC	$ 11,430,183.44	$ 6,847,337.33	$ 18,277,520.77
SD	$ 6,412,125.97	$ 291,019.87	$ 6,703,145.84
TN	$ 15,395,029.80	$ 5,458,261.60	$ 20,853,291.40
TX	$ 28,050,275.35	$ 7,434,925.63	$ 35,485,200.98
UT	$ 11,695,146.07	$ 958,850.34	$ 12,653,996.41
VA	$ 1,299,364.14	$ 9,118,174.73	$ 10,417,538.87
VI	$ 2,937.03	-	$ 2,937.03
VT	$ 887,282.14	$ 749,553.64	$ 1,636,835.78
WA	$ 11,380,648.64	$ 5,049,008.55	$ 16,429,657.19
WI	$ 9,119,962.27	$ 3,776,478.71	$ 12,896,440.98
WV	$ 344,654.93	$ 3,481,684.63	$ 3,826,339.56
WY	$ 3,057,607.49	$ 241,756.22	$ 3,299,363.71
Unknown[1]	$ 33,638,455.24	$ 2,501,693.18	$ 36,140,148.42
Total	***$ 797,447,027.37***	***$ 141,918,041.61***	***$ 939,365,068.98***

[1] At the time the FY 2011 figures were collated, there were some recoveries which could not be specifically linked to a particular state. CMS could link them to a provider and the Recovery Auditor but more detailed analysis was necessary to determine the state.

Appendix D: FY 2011 Corrections by Type of Claim

Corrections by Type of Claim						
	Overpayments Collected		Underpayments Restored		Total Corrected	
Claim Type	*No. of Claims*	*Collected Overpayments*	*No. of Claims*	*Restored Underpayments*	*No. of Claims*	*Total Corrected Amount*
A	174,284	$ 726,020,085.78	41,281	$ 140,689,420.28	215,565	$ 866,709,506.06
B	356,456	$ 37,371,398.24	19,114	$ 1,216,199.22	375,570	$ 38,587,597.46
DME	295,990	$ 34,055,543.35	166	$ 12,422.11	296,156	$ 34,067,965.46
Total	***826,730***	***$ 797,447,027.37***	***60,561***	***$ 141,918,041.61***	**887,291**	***$ 939,365,068.98***

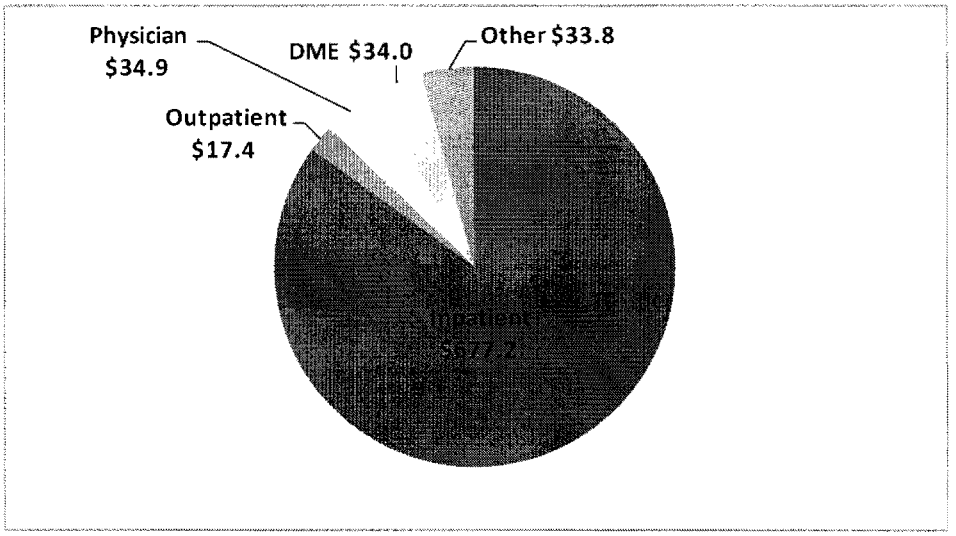
Appendix E: FY 2011 Corrections by Recovery Auditor and Type of Claim

Corrections by Recovery Auditor and Type of Claim							
		Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	*Claim Type*	*No. of Claims*	*Collected Overpayments*	*No. of Claims*	*Restored Underpayments*	*No. of Claims*	*Total Corrected Amount*
A	A	32,928	$ 122,190,944.66	5,680	$ 18,086,931.67	38,608	$ 140,277,876.33
	B	55,416	$ 4,417,207.19	4,301	$ 372,043.07	59,717	$ 4,789,250.26
	DME	9,585	$ 1,198,372.70	0		9,585	$ 1,198,372.70
	Subtotal	*97,929*	*$ 127,806,524.55*	*9,981*	*$ 18,458,974.74*	*107,910*	*$ 146,265,499.29*
B	A	38,545	$ 155,737,429.56	2,856	$ 9,999,709.98	41,401	$ 165,737,139.54
	B	35,770	$ 2,537,529.61	532	$ 34,406.29	36,302	$ 2,571,935.90
	DME	11,900	$ 2,051,728.10	66	$ 1,294.86	11,966	$ 2,053,022.96
	Subtotal	*86,215*	*$ 160,326,687.27*	*3,454*	*$ 10,035,411.13*	*89,669*	*$ 170,362,098.40*
C	A	51,126	$ 163,085,141.41	21,916	$ 69,585,803.12	73,042	$ 232,670,944.53
	B	86,835	$ 10,013,384.28	1,666	$ 51,786.45	88,501	$ 10,065,170.73
	DME	121,163	$ 18,206,267.68	53	$ 8,940.02	121,216	$ 18,215,207.70
	Subtotal	*259,124*	*$ 191,304,793.37*	*23,635*	*$ 69,646,529.59*	*282,759*	*$ 260,951,322.96*
D	A	51,685	$ 285,006,570.15	10,829	$ 43,016,975.51	62,514	$ 328,023,545.66
	B	178,435	$ 20,403,277.16	12,615	$ 757,963.41	191,050	$ 21,161,240.57
	DME	153,342	$ 12,599,174.87	47	$ 2,187.23	153,389	$ 12,601,362.10
	Subtotal	*383,462*	*$ 318,009,022.18*	*23,491*	*$ 43,777,126.15*	*406,953*	*$ 361,786,148.33*
Total		***826,730***	***$ 797,447,027.37***	***60,561***	***$ 141,918,041.61***	***887,291***	***$ 939,365,068.98***

Appendix F1: FY 2011 Corrections by Claim Type

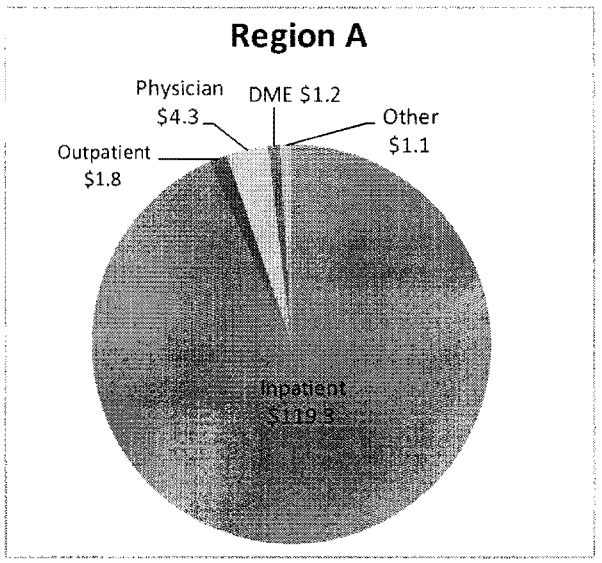
Corrections by Claim Type			
Claim Type	*Collected Overpayments*	*Restored Underpayments*	*Total Corrected Amount*
Inpatient	$ 677,203,117.46	$ 137,760,232.72	$ 814,963,350.18
SNF	$ 218,131.90	$ -	$ 218,131.90
Outpatient	$ 17,414,495.09	$ 629,761.78	$ 18,044,256.87
Physician	$ 34,947,205.05	$ 1,013,931.82	$ 35,961,136.87
Durable Medical Equipment	$ 34,025,622.63	$ 12,422.11	$ 34,038,044.74
Other	$ 33,638,455.24	$ 2,501,693.18	$ 36,140,148.42
Total	***$797,447,027.37***	***$ 141,918,041.61***	***$ 939,365,068.98***

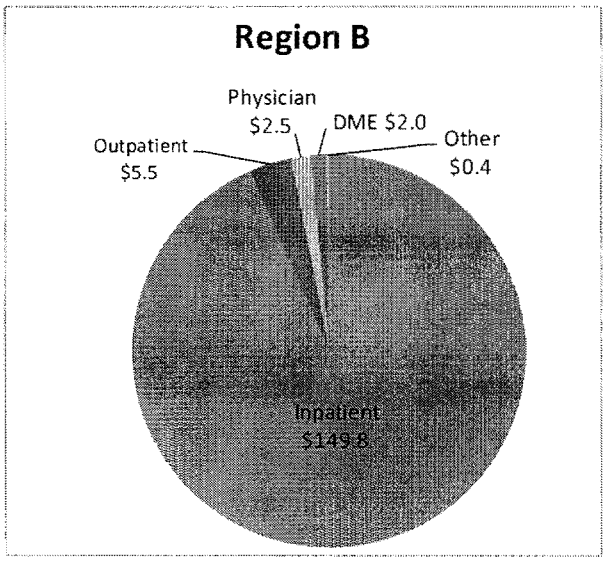
Overpayments by Claim Type (in millions)

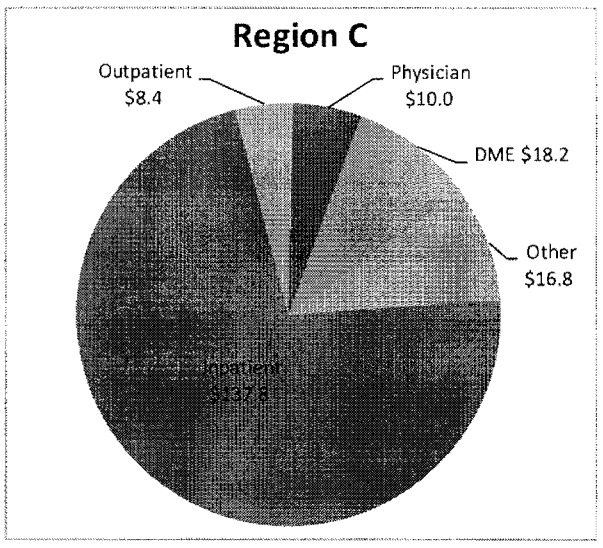


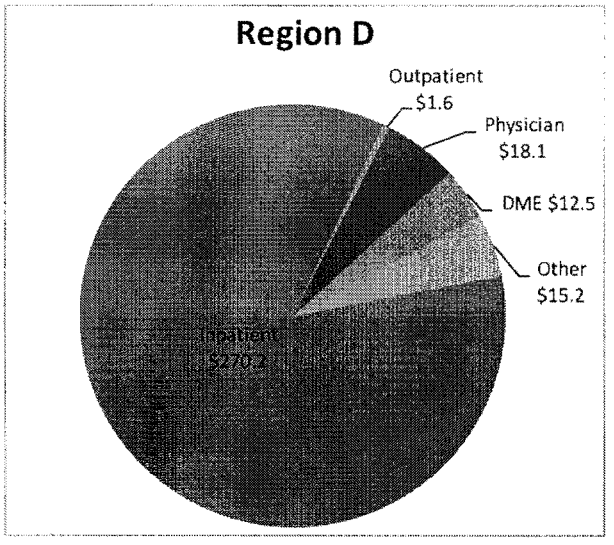
Appendix F2: FY 2011 Corrections by Claim Type and Recovery Auditor

Overpayments by Claim Type (in millions)









Appendix G1: FY 2011 Top Issues by Recovery Auditor- Overpayments

Top Issues by Recovery Auditor- Overpayments				
Recovery Auditor	*Issue Name*	*No. of Claims*	*Total*	*Mean Claim Amount*
A	Medical Necessity Review - Renal and Urinary Tract Disorders	2,226	$ 14,938,043.15	$ 6,710.71
A	Medical Necessity Review - Acute Inpatient Admission, Neurological Disorders; MS-DRGs 068-074, 103, 312	2,990	$ 11,572,643.48	$ 3,870.45
A	MS-DRG Validation - Diseases and Disorders of the Circulatory System	2,153	$ 10,356,710.78	$ 4,810.36
A	MS-DRG Validation - Severe Sepsis	2,112	$ 8,839,411.40	$ 4,185.33
B	Medical Necessity Review - Surgical Cardiovascular Procedures	2,218	$ 25,535,674.99	$ 11,512.93
B	Medical Necessity Review - Renal and Urinary Tract Disorders	2,207	$ 10,386,991.74	$ 4,706.39
B	MS-DRG Validation - Extensive Unrelated OR Procedures; MS-DRGs 981-983	746	$ 7,902,627.14	$ 10,593.33
B	Medical Necessity Review and MS-DRG Validation - Other Vascular Procedures; MS-DRGs 253, 254	611	$ 7,200,699.54	$ 11,785.11
C	Medical Necessity Review - Acute Inpatient Admission, Neurological Disorders	3,444	$ 14,036,688.94	$ 4,075.69
C	Medical Necessity Review - Percutaneous Cardiac Procedures; MS-DRG 249	1,092	$ 10,016,705.01	$ 9,172.81
C	Medical Necessity Review - Other Skin, Subcutaneous Tissue, & Breast Procedures; MS-DRG 581	806	$ 8,007,743.99	$ 9,935.17
C	DME claims billed during an inpatient stay	59,858	$ 6,772,448.51	$ 113.14
D	Medical Necessity Review - Minor surgery and other treatment billed as an inpatient stay	12,266	$144,074,101.66	$ 11,745.81
D	Medical Necessity Review - Acute Inpatient Admission, Neurological Conditions	7,990	$ 34,562,304.51	$ 4,325.70
D	Medical Necessity Review - Renal and Urinary Tract Disorders	1,280	$ 11,126,323.39	$ 8,692.44
D	Medical Necessity Review - Acute Inpatient Admission, Respiratory Conditions	1,647	$ 9,567,939.78	$ 5,809.31

Appendix G2: FY 2011 Top Issues by Recovery Auditor- Underpayments

Top Issues by Recovery Auditor-Underpayments				
Recovery Auditor	*CMS Issue Name*	*No. of Claims*	*Total*	*Mean Claim Amount*
A	MS-DRG Validation - Severe Sepsis	623	$ 1,945,191.10	$ 3,122.30
A	MS-DRG Validation - Lysis of Adhesions	258	$ 1,372,247.04	$ 5,318.79
A	MS-DRG Validation - Complications of Cholecystectomy	291	$ 1,321,046.57	$ 4,539.68
A	MS-DRG Validation - CVA	478	$ 1,288,793.85	$ 2,696.22
B	MS-DRG Validation - Major Small and Large Bowel Procedures	213	$ 1,545,928.54	$ 7,257.88
B	MS-DRG Validation - Intracranial Hemorrhage or Cerebral Infarction	221	$ 685,746.37	$ 3,102.92
B	MS-DRG Validation - Lysis of Adhesions; MS-DRGs 335-337, 350-355	116	$ 611,915.85	$ 5,275.14
B	MS-DRG Validation - Cholecystectomy; MS-DRGs 411-419	80	$ 493,634.36	$ 6,170.43
C	Post Acute Transfers	20,432	$ 63,937,351.31	$ 3,129.28
C	MS-DRG Validation - Extensive OR Procedures; MS-DRG 981	87	$ 418,994.48	$ 4,816.03
C	MS-DRG Validation - Extensive OR Procedures; MS-DRG 983	62	$ 411,759.57	$ 6,641.28
C	Medical Necessity: Acute Inpatient Admission, Neurological Disorders	55	$ 198,853.15	$ 3,615.51
D	Incorrect patient status, acute underpayments	8,503	$ 32,980,112.06	$ 3,878.64
D	MS-DRG Validation - Gastrointestinal Procedures	264	$ 1,845,882.57	$ 6,991.98
D	MS-DRG Validation - Cardiovascular Procedures	127	$ 1,069,486.93	$ 8,421.16
D	MS-DRG Validation - Major diagnostic category 04, Diseases and disorders of the respiratory system	324	$ 1,002,512.12	$ 3,094.17

Appendix H: FY 2011 Cumulative Accuracy Scores

Cumulative Accuracy Score by Recovery Auditor

Recovery Auditor	Cumulative Accuracy Score
Region A DCS	97.2
Region B CGI	95.8
Region C Connolly	97.4
Region D HDI	90.7

Note: In FY 2012, 13 random samples were drawn to determine the accuracy scores. The universe for each region was all claims adjusted by the Recovery Auditor from May 2010 - April 2011. The sample size reviewed for each Recovery Auditor was between 1275 and 1300 claims.

Appendix I1: FY 2011 Appeals by Recovery Auditor

Recovery Auditor	*Type*	*No. of Claims With Overpayment Determina-tions*	*No. of Claims in which Provider Appealed*				*Claims Appealed by Providers at any Level*		*Appealed Claims with Decisions in Provider's Favor*		*Overpayment Determinations Overturned On Appeal (%)*
			FI	*QIC*	*ALJ**	*DAB*	*No. of Claims*	*Percent (%)*	*No. of Claims*	*Percent (%)*	
A	A	36,712	2,322		64		2,386	6%	336	14.1%	0.9%
	B	79,665	515	2	4		521	1%	512	87.3%	0.6%
	DME	4,856	402		10		412	8%	80	19.4%	1.6%
B	A	40,179	8,183	787	79		9,049	23%	3,391	37.5%	8.4
	B	43,459	1,738		47		1,785	4%	717	40.2%	1.6%
	DME	7,003	1,280				1,280	18%	26	2.0%	0.4%
C	A	65,123	5,368	547	13		5,928	9%	1,679	28.3%	2.6%
	B	118,898	509		2		511	0%	210	41.1%	0.2%
	DME	130,284	2,622	48			2,670	2%	1,573	58.9%	1.2%
D	A	55,725	8,479	1,429	18		9,926	18%	1,034	10.4%	1.9%
	B	168,186	16,538	1,096	31		17,665	11%	13,054	73.9%	7.8%
	DME	153,282	4,466	110	40		4,616	3%	2,301	49.8%	1.5%
Unspecified				3,542	426		3,968	0%	1,556	39.2%	0.0%
Total		**903,372**	**52,422**	**7,561**	**734***	**-**	**60,717**	**6.7%**	**26,469**	**43.6%**	**2.9%**

*ALJ level appeals are reported to CMS by the Office of Medicare Hearings and Appeals.

The information provided in the above table is for claims appealed in FY 2011. Many of the claims with appeal decisions may have originating dates prior to FY 2011.

Appendix I2: FY 2011 Appeals by Recovery Auditor

Recovery Auditor	*No. of Claims Appealed*	*No. of Claims Overturned on Appeal*	*Appealed Claims Overturned (%)*	*Total Amount Overturned on Appeal ($)*
A / DCS	3,319	928	28.0%	$ 460,514.85
B / CGI	12,114	4,134	34.1%	$ 16,657,813.97
C / Connolly	9,109	3,462	38.0%	$ 14,522,635.66
D / HDI	32,207	16,389	50.9%	$ 6,243,321.90
Unspecified*	3,968	1,556	39.2%	not known
Total	***60,717***	***26,469***	***43.6%***	***$ 37,884,286.38***

*the unspecified figure includes ALJ decisions reported by the Office of Medicare Hearings and Appeals. While decisions were known, amounts overturned on appeal were not known.

Appendix I3: FY 2011 Appeals by Recovery Auditor

Recovery Auditor	*Type of Review*	*No. of Claims Appealed*	*No. of Claims Overturned on Appeal*	*Appealed Claims Overturned on Appeal (%)*	*Total Amount Overturned on Appeal ($)*
A / DCS	Automated/Unknown	1,323	858	64.8%	$ 132,737.07
	Complex	1,996	70	3.5%	$ 327,777.78
Subtotal		***3,319***	***928***	***27.9%***	***$ 460,514.85***
B / CGI	Automated/Unknown	3,848	1,302	33.8%	$ 447,283.87
	Complex	8,266	2,832	34.3%	$ 16,210,530.10
Subtotal		***12,114***	***4,134***	***34.1%***	***$ 16,657,813.97***
C / Connolly	Automated/Unknown	5,128	2,441	47.6%	$ 4,264,944.68
	Complex	3,981	1,021	25.6%	$ 10,257,690.98
Subtotal		***9,100***	***3,462***	***38.0%***	***$ 14,522,635.66***
D / HDI	Automated	24,262	15,873	65.4%	$ 3,083,634.51
	Complex	7,945	516	6.5%	$ 3,159,687.39
Subtotal		***32,207***	***16,389***	***50.8%***	***$ 6,243,321.90***
Total	Automated/Unknown	***34,561***	***20,474***	***59.2%***	
	Complex	***22,188***	***4,439***	***20.0%***	
	Unspecified	***3,968***	***1,556***	***39.2%***	
Total		***60,717***	***26,469***	***43.6%***	***$ 37,884,286.38***

Appendix J: Amount Returned to the Medicare Trust Fund

Overpayments Collected	-	Underpayments Paid Back to Providers	-	Appeals Reversed	-	Costs to Administer Program*	=	Amount Returned to the Medicare Trust Fund
$797.4 million	-	$141.9 million	-	$37.9 million	-	$129.4 million	=	$488.2 million

*Costs include $81.9 million in contingency fees paid to Recovery Auditors and $47.5 million in CMS administrative costs (costs to adjust claims and hear appeals, support contractors and CMS FTEs)

Appendix K: Recovery Audit Program Informational Resources

G1. Websites with Useful Information and Updates	
Website	**Information Provided**
CMS.gov/recovery-audit-program	This Recovery Audit Program specific agency website encompasses a wealth of information including but not limited to: background information on the program, the Recovery Auditor information for each region, subcontractor information, 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, meant to address common billing errors
Recovery Auditor Websites	These websites will contain the most up to date information on audits conducted and new issues that have been approved. The Recovery Auditor websites are as follows: 1)Region A/DCS: *dcsrac.com* 2)Region B/CGI: *racb.cgi.com* 3)Region C/ Connolly: *connolly.com* 4)Region D/HDI: *healthdatainsights.com*