Medicare FFS Recovery Audit Program

FY 2010REPORT TO CONGRESS OVERVIEW

FY 2010

- ✓ Recovery Audit Program Total Corrections in FY 2010 was 92.3 million.
- ✓ Corrective Actions

Claim Review

- ✓ Recovery Auditors are instructed to review all claim types

- ✓ Types of Claim Reviews currently performed:
  - Complex*
  - Semi-Automated*
  - Automated

**Indicates update*

Claim Review

- ✓ Semi-Automated Claim Review:
  - Introduced in 2010
  - Grants providers the opportunity to send in verifying documentation for claims initially identified as potential improper payments by the Recovery Auditor.

    Benefits of new type of review:

    Allows the provider to decide which claims are correctly coded; whether it is financially beneficial to provide the medical record.

    Allows Recovery Auditors to account for unusual situations in issues otherwise suited for automated review

Claim Review

- ✓ Complex Review of Medical Necessity:
  - CMS permitted this expansion in 2010, after providers and auditors had significant time to adapt to the program and increase familiarity with correct policy application.
  - Medical Necessity review helps to correct an area identified as a large vulnerability by the CERT report: short inpatient hospital stays

    Presidential Objective
  - Only clinicians are permitted to make these decisions

    CMS mandates the use of a Certified Medical Director in each Region

Total Corrections in FY 2010

Total Collections:

- ✓ 75.4 Million

Total Underpayments:

- ✓ 16.9 Million

Nationwide Corrections:

- ✓ 92.3 Million

Corrective Actions

- **Major Findings**
  - MLN Matters
  - Provider Newsletters
  - Quarterly Updates
  - Edits Installed
  - Communication with Associations

Top Issues

Examples of Top Overpayment Issues Identified and Discussed

Region A: Diversified Collection Services

- ✓ Ventilator Support of 96+ hours – Ventilation hours begin with the intubation of the patient (or time of admittance if the patient is admitted while on mechanical ventilation) and continue until the endotracheal tube is removed, the patient is discharged/transferred, or the ventilation is discontinued after a weaning period. Providers are improperly adding the number of ventilator hours resulting in higher reimbursement. (Incorrect Coding)

Region B: CGI, Inc.

- ✓ Extensive Operating Room Procedure Unrelated to Principal Diagnosis– The principal diagnosis and principal procedure codes for an inpatient claim should be related. Errors occur when providers bill an incorrect principal and/or secondary diagnosis that results in an incorrect Medicare Severity Diagnosis-Related Group assignment. (Incorrect Coding)

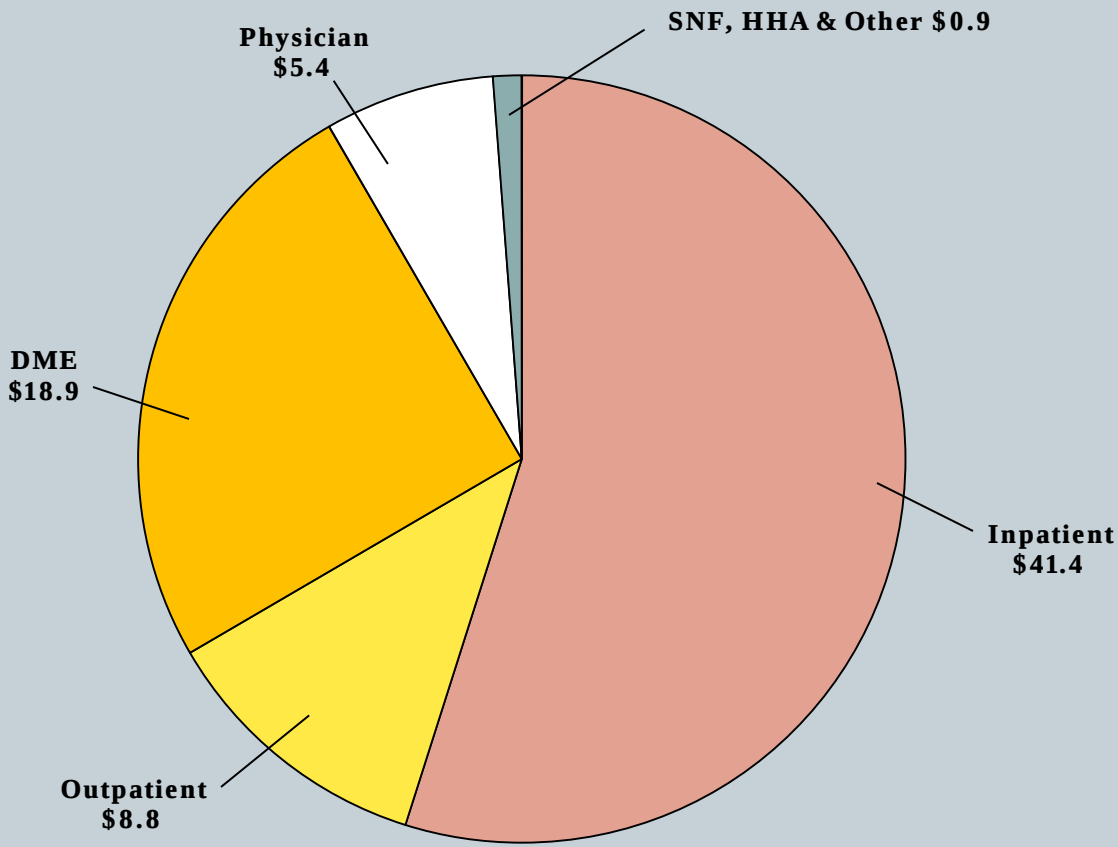
Region C: Connolly, Inc.

- ✓ Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Provided During an Inpatient Stay– Medicare does not make separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. Suppliers are inappropriately receiving separate DMEPOS payment when the beneficiary is in a covered inpatient stay. (Billing for Bundled Services Separately)

Region D:HealthDataInsights

- ✓ Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Provided During an Inpatient Stay– Medicare does not make separate payment for DMEPOS when a beneficiary is in a covered inpatient stay. Suppliers are inappropriately receiving separate DMEPOS payment when the beneficiary is in a covered inpatient stay. (Billing for Bundled Services Separately)

Collections by Claim Type



Appeals Data for FY 2010

Recovery Auditor	Type	No. of Claims with Overpayment Determinations	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 (%)	
Region A: DCS	Part A	858	13	-	-	-	13	1.5	-	-	0.0
	Part B	451	-	-	-	-	-	0.0	-	-	0.0
	DME	8,495	256	-	-	-	256	3.0	27	10.5	0.3
Region B: CGI	Part A	17,294	3,539	1	-	-	3,540	20.5	2,119	59.9	12.3
	Part B	1,796	71	-	-	-	71	4.0	49	69.0	2.7
		737	1	-	-	-	1	0.1	1	100.0	0.1
Region C: Connolly	Part A	13,307	772	20	3	-	795	6.0	150	18.9	1.1
	Part B	88	24	-	-	-	24	27.3	-	-	0.0
	DME	7,638	-	-	-	-	-	0.0	-	-	0.0
Region D: HDI	Part A	12,488	628		-	-	628	5.0	285	45.4	2.3
	Part B	36,980	510	5	-	-	515	1.4	28	5.4	0.1
	DME	63,507	2,601	5	-	-	2,606	4.1	1,243	47.7	2.0
Total		**163,639**	**8,415**	**31**	**3**	-	**8,449**	**5.2**	**3,902**	**46.2**	**2.4**

Continuous Improvement

- ✓ MAC-issued Demand Letters to ensure timeliness
- ✓ Automated Appeals Tracking Systems

  Each level has separate and often unrelated methods of claim identification.
- ✓ Review Rationale Letters

  Details= Education
- ✓ Increased Appeals Involvement

  Benefits: Provider Education; Weak Policy Identification
- ✓ Increasingly Electronic

  Health Records; File Transfers