Recovery Auditing in Medicare for Fiscal Year 2014

FY 2014 Report to Congress as Required by Section 1893(h) of the Social Security Act

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Executive Summary

The fee-for-service (FFS) Medicare Recovery Audit Program is authorized under Section 1893(h) of the Social Security Act (the Act). Section 1893(h)(8) requires the Secretary to "annually submit to Congress a report on the use of recovery audit contractors…" In addition, "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…" This report satisfies that requirement.

The mission of the Recovery Audit Program is to identify and correct Medicare and Medicaid improper payments through the efficient detection and collection of overpayments made on claims for health care services provided to Medicare and Medicaid beneficiaries, to identify underpayments to providers, and to provide information that allows the Centers for Medicare & Medicaid Services (CMS) to implement actions that will prevent future improper payments.

CMS oversees several different Recovery Audit Programs, such as those for FFS Medicare and Parts C and D. States oversee their own Medicaid Recovery Audit Programs in accordance with federal guidelines set by CMS. This report focuses only on the FFS Medicare Recovery Audit Program. Information on the other Recovery Audit Programs will be reported separately.

Medicare FFS Recovery Audit Program

The Medicare FFS program consists of a number of payment systems. The program 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[1]. These 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.

CMS uses several types of contractors to verify that paid claims are paid based on Medicare guidelines. One type of contractor used is a Recovery Auditor, also known as a Recovery Audit Contractor (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 mandated that the Recovery Audit Program expand to all the states 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.

[1] For the purposes of this report, we use the term "provider" to refer to any provider or supplier who bills FFS Medicare.

In FY 2014, CMS continued the demonstration program to use Recovery Auditors for the purpose of reviewing certain claims before they are paid, known as prepayment review. The demonstration started on September 1, 2012 and is scheduled for a total of three years in the following 11 states: California, Florida, Illinois, Louisiana, Michigan, Missouri, New York, North Carolina, Ohio, Pennsylvania, and Texas. The goal of the demonstration is to lower the number of improper payments for those claims that are shown through Comprehensive Error Rate Testing (CERT) reports and other data analysis to have high rates of improper payments. As part of the prepayment review demonstration program, Recovery Auditors prevented over $51.8 million in improper payments.

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. CMS hosts regular meetings with the Recovery Auditors, MACs, and CMS staff to discuss best practices, particular vulnerabilities, and future corrective actions, including CMS educational articles, local and national system edits, and additional review by other entities. 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.

CMS continues to make improvements to the Recovery Audit program to help alleviate provider burden, verify 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 electronic transmission of medical documentation and help eliminate the costly and time-consuming need for providers to mail paper records for contractor review. 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. The Recovery Auditor Data Warehouse, the clearinghouse for all Recovery Auditor review activity, has been successful in preventing duplicate reviews of the same claim among all review contractors. CMS is continuing to make improvements to the Data Warehouse and currently requires Recovery Auditors and other review contractors to use the Data Warehouse to prevent another review entity from selecting a previously reviewed claim.

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, which is administered by the Office of Medicare Hearings and Appeals (OMHA). The Recovery Auditors are involved in appeals meetings between other CMS review entities, such as MACs and Zone Program Integrity Contractors (ZPICs), and CMS appeals contractors, such as the Qualified Independent Contractors (QICs) and the Administrative QIC (AdQIC), to discuss trends in appeals, as well as best practices for creating position papers to use at ALJ hearings. Involvement by Recovery Auditors in ALJ appeals aids in contractor and provider education, as it presents a forum for discussion, assists in identifying erroneous billing practices for providers, and assists in identifying policies that need clarification.

In Fiscal Year (FY) 2014, Recovery Auditors collectively identified and corrected 1,117,057 claims for improper payments that resulted in $2.57 billion dollars in improper payments being corrected. The total corrections identified include $2.39 billion in overpayments collected and $173.1 million in underpayments repaid to providers (see Table 1). After taking into consideration all costs of the program, including contingency fees, administrative costs, and amounts overturned on appeal, the Medicare FFS

Recovery Audit Program returned over $1.6 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 [OMHA] and Medicare Appeals Council within the Departmental Appeals Board [DAB),)], respectively), as these components do not receive Recovery Audit Program funding for those appeals. CMS attributes some of the decrease in corrections from previous years to the limited amount of reviews that took place during the close-out process of the existing Recovery Auditor contracts. Additionally, after the publication of the 2014 Inpatient Prospective Payment System (IPPS) Final Rule, CMS prohibited the Recovery Auditors from performing inpatient hospital patient status reviews on claims for dates of admission on or after October 1, 2013 and allowed the MACs to engage in a Probe and Educate process for the new hospital admissions policy. Inpatient hospital patient status reviews previously accounted for a substantial portion of Recovery Auditor corrections.

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.

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.

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, Medicaid, and the Children's Health Insurance Program (CHIP) in accordance with the *Improper Payments Information Act of 2002 (IPIA),* as amended by the *Improper Payments Elimination and Recovery Act of 2010 (IPERA)* and the *Improper Payments Elimination and Recovery Improvement Act of 2013 (IPERIA).*[2]

As part of its efforts to implement the IPIA, CMS uses the 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 Medicare FFS Recovery Audit program and the MACs[3]. The 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. 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.

The ZPICs, whose primary role is to investigate instances of suspected fraud, waste, and abuse, provide additional protections for reducing improper payments, 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 confirm the work is collaborative and not duplicative. The Recovery Auditor Data Warehouse was developed to serve as the primary source of data for the Medicare FFS Recovery Audit Program. CMS uses the Data Warehouse to prevent Recovery Auditors and other review entities from reviewing claims that were previously subjected to medical record review by another review entity, such as a MAC, or that are currently under review by law enforcement. All review contractors are instructed to upload the claims they are reviewing into the Data Warehouse. Contractors are then instructed to check the Data Warehouse for any existing activity on the claims under consideration for review prior to beginning those reviews. A claim that has been reviewed by one entity is not available to another entity for review, absent potential fraud. CMS is continuously working to improve the collaboration between auditing contractors

[2] Additional information about the Medicare Fee-for-Service national error rate can be found at go.cms.gov/CERT Additional information about the Medicaid national error rate can be found at go.cms.gov/PERM

[3] Effects of Recovery Auditor reviews may not be immediately realized in the CERT report, due to differences in the Recovery Auditor look-back period and the CERT reporting period.

to promote accurate and efficient auditing of Medicare claims while reducing provider burden and ensuring beneficiary access to health care/health services.

Improper Payments in Medicare

Claims submitted to Medicare are screened by thousands of system edits prior to payment. However, given the volume of claims submitted to Medicare on a daily basis, CMS is not able to perform 100 percent medical review prior to payment, commonly referred to as prepayment review. CMS must rely on conducting medical record review after payment, commonly referred to as postpayment review. Overall, CMS manually reviews less than 0.3 percent of submitted claims each year through auditing programs, including those reviewed through the Recovery Audit Program. As a result of the need to rely on postpayment review, claims initially 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, or
- Payment is made for services where the documentation submitted does not support the ordered service.

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.[4] 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 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, which authorized the Recovery Audit Program expansion nationwide by January 2010, requires an annual Report to Congress, including information on the performance of such contractors on identified underpayments and overpayments and recouping overpayments including an evaluation of the comparative performance of such contractors and savings to the program (Appendix A). This report satisfies that requirement.

The Use of Recovery Auditors

The Recovery Audit Program is an important initiative in CMS' 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

[4] For more information on the Recovery Audit program demonstration see the Recovery Audit Program website section on "Historical Programs"

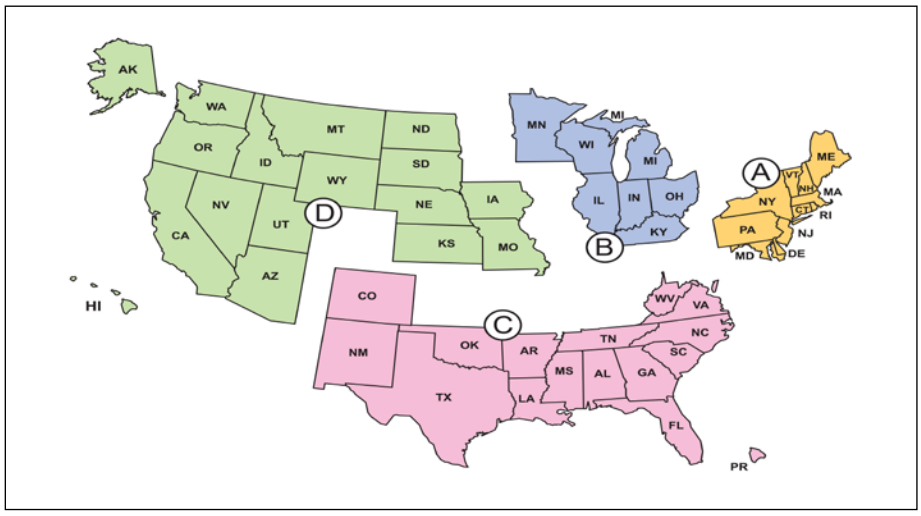
errors, trends, and other Medicare payment issues. Recovery Auditors are unique and distinct from other contractors due to their ability to conduct widespread postpayment review.

The Recovery Auditors in each region in FY 2014 were:

- Region A: Performant Recovery
- Region B: CGI
- Region C: Connolly
- Region D: HealthDataInsights (HDI)

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

Figure 1:



How Recovery Auditors are Paid

As required by Section 1893(h) of the Act, 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 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 contingency fee if an improper payment determination is overturned at any level of appeal.

Procurement and Contract Modification

In February 2013, CMS issued a Request for Quotations (RFQ) through the General Services Administration (GSA) Federal Supply Schedule Program for the new Recovery Audit Program contracts. Shortly after the release of the RFQ, CMS received a pre-award protest alleging that the transition plan CMS outlined would treat bidders differently. CMS began voluntary corrective action, and the Government Accountability Office (GAO) dismissed the protest.

Between December 2013 and January 2014, after taking voluntary corrective action, CMS issued five separate RFQs for the new Recovery Auditor contracts: four Part A/B Recovery Auditors and one

DME/Home Health and Hospice (HH&H) Recovery Auditor. At this time, CMS began the close-out process for the existing contracts by prohibiting Recovery Auditors from sending ADR letters after February 28, 2014[5] and prohibiting Recovery Auditors from sending claims for adjustment after June 1, 2014.

In January and February 2014, the four Part A/B Recovery Auditor contracts were protested at the GAO. The protesters alleged, among other allegations, that the Recovery Auditor payment terms restricted competition and were otherwise inconsistent with Part 12 of the Federal Acquisition Regulation (FAR). On April 23, 2014, CMS received a favorable ruling from the GAO. However, one protestor then appealed to the Court of Federal Claims. In June 2014, CMS agreed to voluntarily stay award of the contracts until after August 15, 2014.

Concerned that any further delay in awarding new contracts would negatively impact the program's ability to detect improper payments, achieve continuity of operations, and meet operational obligations, on August 4, 2014, CMS announced that it was initiating contract modifications to the existing Recovery Auditor contracts to allow the current Recovery Auditors to restart a portion of their reviews. Most reviews were required to be completed on an automated basis, but a limited number of complex reviews of topics selected by CMS were approved.

On August 22, 2014, CMS received a favorable ruling from Court of Federal Claims. However, the protestor then appealed to the Court of Appeals for the Federal Circuit. The protestor prevailed and the Court determined that the provisions of FAR Part 12 apply to purchases made by agencies placing orders using the GSA schedule. On June 4, 2015, CMS withdrew the RFQs and is evaluating how to best proceed with the new Recovery Auditor contracts.

[5] Because no ADR letters were sent after February 2014, the Recovery Audit Prepayment Demonstration, occurring in 11 states, was essentially "paused."

Recovery Audit Review Process

The Recovery Auditors review Medicare FFS claims on a postpayment[6] basis using the same Medicare policies and regulations as other Medicare contractors. CMS limits the claims eligible for Recovery 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:

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 initiated with data analysis; however, providers may submit supporting documentation to substantiate the claim.
- **Complex**: These reviews require 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 improper payment 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 submit additional documentation to substantiate their claims and 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 payment 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, which initially flow from the remittance advice. The MACs have full responsibility of issuing demand letters related to Recovery

[6] See page 17 for a discussion of the Recovery Auditor prepayment review demonstration.

Auditor-initiated overpayments. This streamlines all adjustment correspondence and activities to enhance the timeliness of demand notifications.

Collection and Repayment

The MACs are responsible for the collection efforts of overpayments and payment 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 the event a valid appeal is received, recoupment is delayed during the first two levels of appeal.

Appeals

Providers who disagree with a Recovery Auditor's improper payment determination may utilize the multilevel administrative appeals process under Section 1869 of the Act. Recovery Audit appeals follow the same appeal process as other Medicare claim determinations. The levels of appeal are described below.

Redetermination:

Performed by MACs, the request for redetermination must be received by the MAC within 120 calendar days of the date a party receives the initial (or revised initial) determination, and written notice of the redetermination is expected to be mailed or otherwise transmitted by the MAC within 60 calendar days of receipt of the request for redetermination.

Reconsideration:

Performed by Qualified Independent Contractors (QICs), the request for reconsideration must be filed with the QIC within 180 calendar days of the date the party receives the Medicare Redetermination Notice. The QICs are expected to mail or otherwise transmit notice of the reconsideration within 60 calendar days of receipt of the request for reconsideration.

Administrative Law Judge (ALJ):

ALJ hearings require a minimum amount in controversy ($140 for Calendar Year (CY) 2014), and a request for a hearing must be filed within 60 calendar days of the date the party receives the reconsideration notice. Generally, ALJs are expected to issue a decision, dismissal order, or remand to the QIC within 90 calendar days of the date the request for hearing is received. If an ALJ does not act in a timely manner, the appellant may choose to escalate that appeal to the next level of review if certain conditions are met. Due to substantial increases in the number of appeals filed at the ALJ level, including increases in appeals of Recovery Auditor determinations, coupled with only moderate increases in ALJ funding, adjudication timeframes have generally been exceeding 90 days.[7]

[7] See the website for the Office of Medicare Hearings and Appeals for more information.

Medicare Appeals Council within the DAB (the Appeals Council):
A request for review by the Council must be filed within 60 calendar days after receipt of the ALJ decision or dismissal, and the Council generally issues a decision, dismissal order or remand order to the ALJ within 90 calendar days of receipt of the request for review. Due to substantial increases in the number of appeals filed at this level, adjudication timeframes have generally been exceeding 90 days. There is no minimum amount in controversy at this level.

Judicial Review (Federal District Court Review):

Appeals to Federal district court must be filed within 60 calendar days of the date a party receives notice of the Council's decision, but the federal court does not have a deadline to issue its decisions. For CY 2014, the minimum amount in controversy was $1,430.

Prepayment Review

As part of the prepayment demonstration that was approved and implemented in late FY 2012, Recovery Auditors started reviewing certain error-prone claims before they were paid. In collaboration with the MACs, CMS implemented claims processing edits that would flag some claims for further review. Providers who billed these claims receive additional documentation request letters requiring the submission of medical records for review. After review, the Recovery Auditors send a review results letter to the provider and communicate with the MACs as to whether the claim should be paid or denied. Providers may still appeal denied prepayment review claims, and they are generally off limits for further postpayment reviews. More information on the Prepayment Review Demonstration can be found in the Results Section on page 17.

Short-Stay Inpatient Hospital Admission Claims

The majority of the Recovery Audit Program appeals at the ALJ level in FY 2014 focused on short-stay inpatient hospital claims with overpayment determinations made prior to the moratorium on inpatient hospital patient status reviews. In reviewing these claims, the Recovery Auditors 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 contributed to backlogs at OMHA, the agency that oversees the third level of appeals.

In August 2013, CMS published a final rule updating fiscal year FY 2014 Medicare payment policies and rates under the IPPS and the Long-Term Care Hospital Prospective Payment System (LTCH PPS). The final rule modified and clarified CMS' longstanding policy on how Medicare contractors review inpatient hospital and critical access hospital admissions for payment purposes. Under the final rule, certain services are generally appropriate for inpatient hospital admission and payment under Medicare Part A when (1) the physician 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.

CMS subsequently established the Probe and Educate process, which directed MACs to review inpatient hospital claims and provide education to providers in accordance with the final rule until December 31, 2013. Additionally, CMS prohibited Recovery Auditors from conducting inpatient hospital patient status reviews on claims with dates of admission between October 1, 2013 and December 31, 2013. CMS later extended these policies through September 30, 2014. With the enactment of the Protecting Access to

Medicare Act of 2014 (PAMA) on April 1, 2014, the Secretary was permitted to continue the Probe and Educate process until March 31, 2015 and continue the prohibition on Recovery Auditors from conducting patient status reviews for inpatient claims with dates of admission through March 31, 2015. In the CY 2016 OPPS proposed rule, CMS is proposing to change the standard by which inpatient admissions generally qualify for Part A payment based on feedback from hospitals and physician to reiterate and emphasize the role of physician judgment. And, CMS is announcing a change in the enforcement of the standard so Quality Improvement Organizations (QIOs) will oversee the majority of patient status audits, with the Recovery Audit program focusing on only those hospitals with consistently high denial rates. The comment period on this proposed rule closed on August 31, 2015.

Key Program Components

CMS has identified five key factors for measuring the success of the Recovery Audit Program: increasing accuracy, implementing effective and efficient program operations, 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 seeks to identify problems and develop solutions early and to discuss those issues with all parties.

Increasing Accuracy

CMS has implemented several elements to verify that 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. This occurs through a CMS Recovery Audit Review Plan Team that is comprised of CMS policy and coverage staff and clinicians. This allows the appropriate CMS personnel to both be aware of, and approve what the Recovery Auditors are reviewing (including all automated, semi-automated, and complex reviews), and that the Recovery Auditors have the correct interpretation of the policies used in their audit methodologies. During these team 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. These discussions may lead to CMS updating certain coverage or billing guidelines to align with more current practices. Two examples of updated guidelines from previously identified vulnerabilities are those related to inpatient hospital patient status reviews and Inpatient Rehabilitation Facility (IRF) admissions. In 2013, Final Rule 1599-F clarified and modified CMS' policy regarding when inpatient hospital admissions are payable under Medicare Part A. Similarly, the FY 2010 Final Rule for the IRF PPS (CMS-1538-F) implemented new coverage requirements for the IRF benefit. The final rule clarified the new required documentation and criteria in order for IRF admissions to be considered reasonable and necessary.

CMS can also use the expertise of the MACs to review potential review topics, such as automated, semi-automated, and complex coding, and make recommendations to CMS regarding approval. This allows the contractor that implemented the policy to be aware of the audit and to make sure the Recovery Auditors are correctly interpreting the policies in their region.

Recovery Auditors are also required to have at least one full time Contractor Medical Director (CMD) on staff and to arrange for an alternate when the CMD will be unavailable for extended periods. 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 the overall processes of medical review and quality assurance to make sure 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 allows for greater education. Several Recovery Auditors have added additional full-time or part-time CMDs to provide greater clinical guidance and assistance to staff, providers, and CMS. Recovery Auditors also sometimes utilize additional clinical resources that are not dedicated to the Recovery Audit Program.

To confirm 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 a Recovery Auditor 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 RVC's review. In FY 2014, each Recovery Auditor had an overall accuracy score of 91 percent or higher for claims adjusted from August 2013 through July 2014(see Appendix J).

The RVC is also tasked with conducting special studies of Recovery Auditor findings. In FY 2014, the RVC performed 4 special studies on claims reviewed by all 4 Recovery Auditors. 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 4,812 claims as part of its oversight activities. CMS uses the results from the RVC in its assessment of the Recovery Auditors' performance. The accuracy rates and special study results are part of the Recovery Auditor's Contractor Performance Assessment Rating System (CPARS) overall performance rating for the year. These results are available to all federal agencies and are included in the Recovery Auditor's performance evaluations, which are used in subsequent contract award considerations. Poor performance may result in negative performance evaluations and a possible termination of the Recovery Auditor's work.

Implementing Effective and Efficient Program Operations

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 opportunities for discussion among contractors to address operational issues and concerns that may impede program efficiency. CMS continues to support 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 streamlined claim processing, changes in the operational process to allow for more efficient communications, and contractor sharing of identified program vulnerabilities for potential review.

CMS also continues to improve the Recovery Auditor Data Warehouse to track greater audit detail and information. The Data Warehouse was developed to serve as the primary source of data for the Medicare FFS Recovery Audit Program and was initially designed to prevent Recovery Auditors and other review contractors from reviewing claims that were previously subjected to medical record review by another review entity, such as a MAC, or that are currently under review by law enforcement. CMS has implemented several systems changes to allow for more reporting of MAC and ZPIC reviews, including both prepayment and postpayment data. CMS has also required other review contractors to check the Data Warehouse before selecting a previously reviewed claim for further review. CMS is planning future changes to continuously improve our ability to prevent review of the same provider or same issue by two different review contractors at the same time. CMS continues to improve the Data Warehouse functionalities to allow more data storage and collection and to automate the process of data collection as much as possible. CMS and the Data Warehouse users also engage in regular communication dedicated to Data Warehouse operational issues.

CMS is continuing to use the esMD program 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 2014, all Recovery Auditors continued to be voluntary participants in the esMD 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] CMS also posts the Recovery Auditor statement of work and educational articles aimed at preventing future improper payments. The 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.

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

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. CMS has imposed additional documentation request limits on the number of medical records a Recovery Auditor may request in a 45-day timeframe. CMS has amended the limits so that requests must be spread across several different provider types, as opposed to requesting only one type of record for a practice/facility. For example, if a provider has inpatient hospital, outpatient hospital, inpatient rehabilitation facility, and physician claims, the Recovery Auditor may only select the maximum percentage of inpatient hospital claims (or any other one particular claim type), and the balance of the additional documentation requests (ADRs) must be selected from the remaining claim types. 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 I shows the rate of which ADRs result in improper payments for each Recovery Auditor. CMS continues to analyze provider billing data in an effort to more fairly calculate the ADR limits.

As previously discussed, all Recovery Auditors accept esMD submissions to minimize provider and supplier burden associated with medical documentation requests. The acceptance of esMD helps minimize the time necessary to respond to Recovery Auditor requests and offers another alternative for

[8] This information is posted at go.cms.gov/RAC under the "Recent Updates" download section.

providers to safely and quickly transport the documentation. CMS understands that additional staffing is often required to address Recovery Auditor correspondence and is constantly working to improve processes to allow providers to respond to requests without having a negative impact on 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 verify that all customers receive professional and knowledgeable assistance with timely follow-up when necessary. Personnel are required to return telephone calls within 1 day, respond to electronic inquiries within 2 days, and respond to written requests within 30 days. The MACs are also available to address any Recovery Audit program questions dealing with claim adjustments, 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. CMS also works to prevent multiple review entities, such as Recovery Auditors, MACs, and ZPICs from reviewing the same providers and the same topics at the same time. 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. 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. 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 information regarding 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.

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 promote uniformity in policy application and examine methods for correction and future trust fund protection. 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.

FY 2014 Results

Performance of the Recovery Auditors

In FY 2014, the Recovery Auditors identified and corrected $2.57 billion in improper payments. There were $2.39 billion collected in overpayments and $173.1 million in identified underpayments paid back to providers (see Table 1). In FY 2014, program corrections were $1.2 billion, or 31.5% below program corrections in FY 2013. CMS attributes some of the decrease in corrections from previous years to the limited reviews that took place during the close-out process of the existing Recovery Auditor contracts. While CMS was engaged in the procurement process for the next round of Recovery Auditor contracts, resources were focused on completing as many open reviews as possible. For example, CMS prohibited Recovery Auditors from sending ADRs to initiate new complex reviews after February 2014 and all claim adjustment files had to be sent to the MACs by June 2014. During this time, Recovery Auditors continued to complete open reviews, maintain their customer service obligations, and support the appeals process. Additionally, after the publication of the IPPS Final Rule, CMS prohibited the Recovery Auditors from performing inpatient hospital patient status reviews for claims with dates of admission on or after October 1, 2013 and allowed the MACs to engage in a Probe and Educate process for the new hospital admission policy. Inpatient hospital patient status reviews previously accounted for a substantial portion of Recovery Auditor corrections.

Table 1

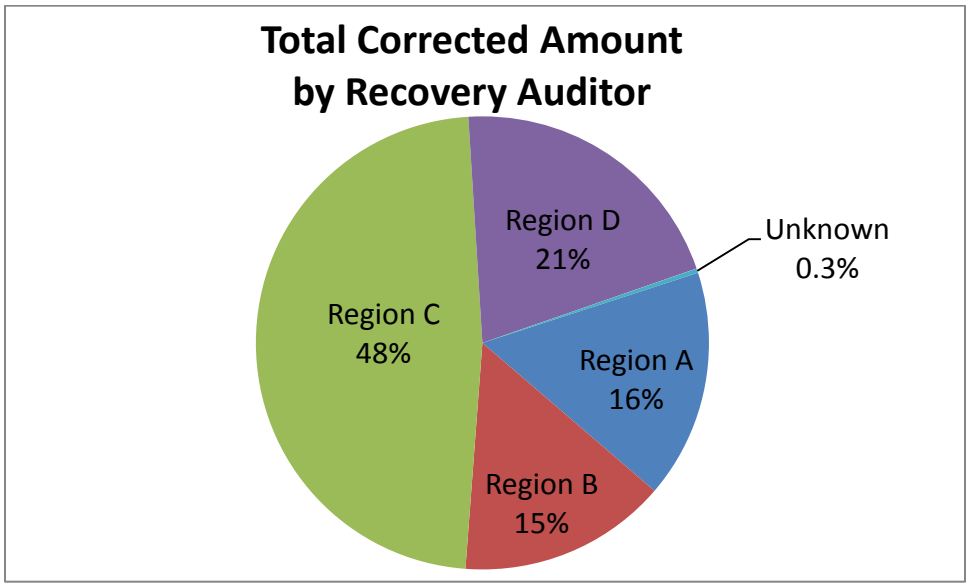
Corrections by Recovery Auditor						
	Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	No. of Claims	Amount Collected	No. of Claims	Amount Restored	No. of Claims	Amount Corrected
Performant	122,853	$407,102,179	3,260	$11,430,299	126,113	$418,532,478
CGI	149,720	$347,841,963	15,526	$34,516,025	165,246	$382,357,988
Connolly	401,213	$1,130,851,250	42,547	$97,019,362	443,760	$1,227,870,612
HDI	361,888	$504,446,531	14,612	$26,711,132	376,500	$531,157,663
Unknown[9]	3,623	$4,604,228	1,815	$3,420,086	5,438	$8,024,314
Total	***1,039,297***	***$2,394,846,151***	***77,760***	***$173,096,904***	***1,117,057***	***$2,567,943,053***

[9] Due to changing MAC workload numbers, these claims could not be attributed to a specific Recovery Auditor in the Data Warehouse. No Recovery Auditor has been paid contingency fees for the correction of these claims.

Evaluation of the Comparative Performance of the Recovery Auditors

The Region C Recovery Auditor, Connolly, had the most corrections in terms of both overpayments and underpayments. Connolly corrected over 47% of the total improper payments for the Recovery Audit Program with over $1.2 million in total corrections (see Figure 2). HDI, the Region D Recovery Auditor corrected less than half of Connolly's total corrections, with $0.5 million. The Recovery Auditors in Region A and B, Performant and CGI, respectively, both corrected approximately 0.4 million in improper payments.

Figure 2



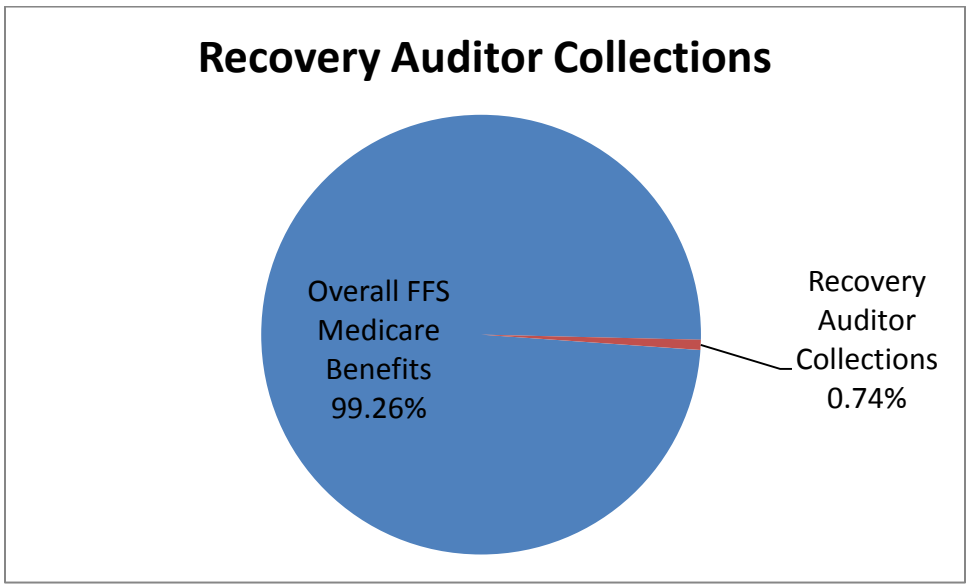
Savings to the Medicare Program

After taking into consideration the Recovery Audit Program's administrative costs, underpayments paid to providers, and appeal reversals, the Medicare FFS Recovery Audit Program returned $1.6 billion to the Medicare trust funds in FY 2014 (see Appendix B). CMS spent $460.9 million to operate the Medicare FFS Recovery Audit Program, of which $274.6 million were contingency fees paid to Recovery Auditors. Administrative costs, such as processing appeals at the first two levels, adjusting claims, support contractors, and oversight of the program, accounted for the additional $186.3 million. These amounts do not take into account costs incurred at the third and fourth levels of appeal (OMHA and the Medicare Appeals Council within the DAB, respectively), as these components do not receive Recovery Audit Program funding for those appeals.

This equates to a Return on Investment (ROI) of over 2:1. Included in the ROI calculation is $173.1 million in underpayments that were paid back to providers. Although this lowers the Recovery Audit Program's overall ROI, identifying and returning underpayments is an important part of the Program.

Compared to overall FFS expenditures, the amount collected by Recovery Auditors is relatively small. Figure 2 illustrates that Recovery Auditors collected less than 1 percent of the over $364.5 billion that Medicare paid in benefits in FY 2014. CMS believes that even this small percent of corrections creates a sentinel effect in the industry. Providers become more aware of the importance of supporting their billing in case of potential Recovery Auditor reviews.

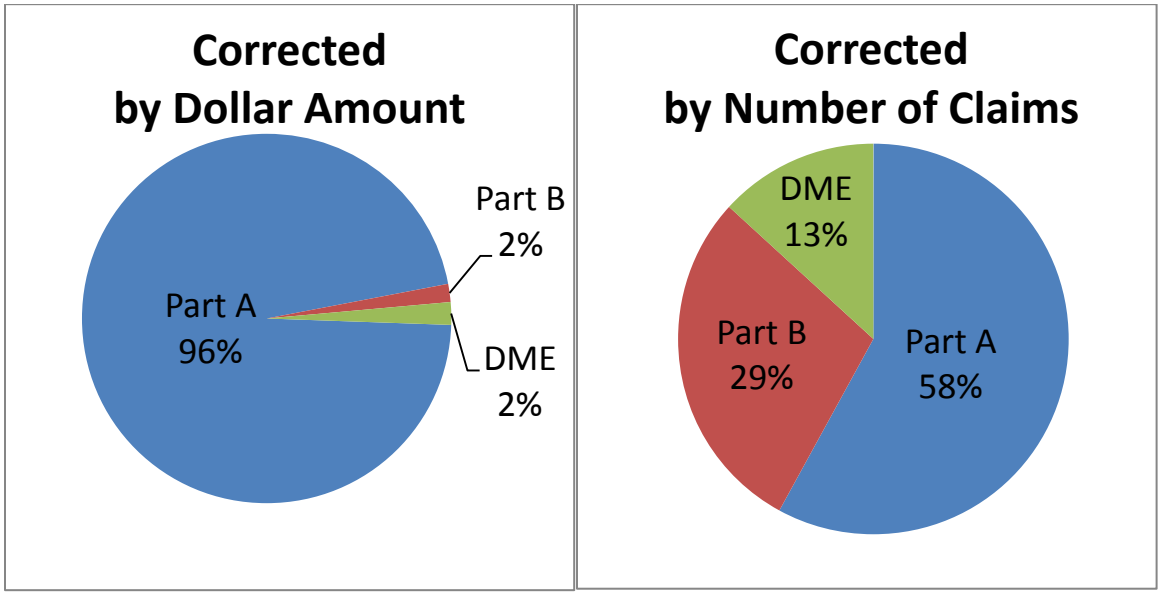
Figure 3



Additional Analysis

Appendix C describes corrections information for each state. Figure 3 shows that the majority of improper payments in FY 2014 were from Part A claims, with 2 percent attributable to each Part B and DME claims. Appendices D and E show the breakdown of improper payment corrections for claim and provider types, as compared to the total Medicare benefit payments by claim and provider types. Appendix F shows the breakdown of improper payment corrections for claims reviewed by each Recovery Auditor.

Figure 4



Although Recovery Auditors did not perform any medical necessity or inpatient hospital patient status reviews on inpatient hospital claims with dates of admission in FY 2014, over 84 percent of overpayments collected (more than $2 billion) continued to come from inpatient hospital claims

(Appendices F and G). These included collections from patient status reviews that occurred prior to FY 2014, as well as coding validation and other types of inpatient hospital reviews. CMS originally prohibited the Recovery Auditors from performing inpatient hospital patient status reviews after the publication of the 2014 IPPS Final Rule 1599, which modified and clarified CMS' policy regarding how Medicare contractors review inpatient hospital admissions for payment purposes. CMS subsequently implemented the Probe and Educate process, which directed MACs to review, on a prepayment basis; inpatient hospital claims and provide education to providers in accordance with this policy. These initiatives were further extended throughout FY 2014.

The Recovery Auditors performed more complex reviews (over 49 percent) than automated reviews and semi-automated reviews, with the vast majority of the improper payments collected coming from complex reviews (over 93 percent). Appendix H includes additional information about the improper payment and claim corrections by the type of review performed.

Appeals

Beneficiaries and providers generally have the right to appeal any Medicare coverage or payment determination through Section 1869 of the Act. CMS strives to lower the appeal rate, which in turn reduces the administrative costs of the program, as well as provider burden. In FY 2014, providers initially appealed 432,075 unique claims, which constituted 59 percent of all claims with overpayments identified by the Recovery Auditors that year[10] (Appendix K1). Throughout all four levels of administrative appeal, providers appealed 799,141 claims identified by the Recovery Auditors in FY 2014[11]. Of the total claims appealed, 182,856 claims, or 22.9% were overturned with decisions in the provider's favor (see Appendix K5).

Determinations are overturned for a variety of reasons including:

- ALJs are bound by the Medicare statute, Medicare regulations, National Coverage Determinations (NCDs), and CMS rulings. ALJs are required to provide substantial deference to CMS manuals and Local Coverage Determinations (LCDs) when they are applicable to a particular case, but are not bound by them. By contrast, Recovery Auditors are required to make their claim decisions based on all CMS policies including CMS manuals and LCDs. This may create discrepancies between the ALJ decisions and the Recovery Auditor determinations.[12]
- 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 Auditors at the time they made their original decision. Recovery Auditors allow providers multiple attempts to provide documentation supporting their claim prior to issuing a

[10] Appeals are based on claims with overpayment *determinations* (i.e. claims with demand letters), not claims with overpayment *corrections*, which are stated throughout this report.

[11] Claims may have had initial overpayment determinations made prior to FY 2014. Appealed claims may be counted multiple times if the claim had appeal decisions rendered at multiple levels during FY 2014. For example, if a claim was appealed to the first level and received a decision in FY 2014, then appealed to the second level and received a decision in FY 2014, both decisions are counted.

[12] OEI-02-10-00340 - Improvements Are Needed At The Administrative Law Judge Level of Medicare Appeals

notification letter. 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 regarding the claim as it was billed. Automated and semi-automated reviews are often denied correctly. However, as noted above, the provider can correct billing errors 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. 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.

CMS has made changes to the review approval process to even further improve the Recovery Auditors' identifications, as well as the appeals overturn rate. 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 issues so the provider can avoid the burden of the appeals process when issues do occur.

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

Prepayment Review Demonstration

In September 2012, CMS began allowing Recovery Auditors to review claims before they are paid as part of the Recovery Auditor Prepayment Review Demonstration. The demonstration is being conducted in seven states with high incidences of improper payments and fraud (California, Florida, Illinois, Louisiana, Michigan, New York, and Texas), as well as four states with the high numbers of short hospital stays (Missouri, North Carolina, Ohio, and Pennsylvania).

Under this demonstration, the Recovery Auditors review the submitted documentation for the selected claims before they are paid to verify 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 it prevented from being improperly paid. The Recovery Auditors are required to complete the review of these claims within 30 days of receiving the documentation. As a result, the approved claims are paid in a timely manner.

A goal of this 3-year demonstration is to lower the number of improper payments for claims identified through the CERT Error Rate data. During this time, CMS will assess the impact on the provider community from increasing the number of prepayment reviews before permanent policy changes are implemented.

The Recovery Auditors began with reviewing short-stay inpatient hospital claims. In addition, certain Medicare Severity – Diagnosis Related Groups (MS-DRGs) were selected for review based on CERT data. Certain claims in these states containing a selected MS-DRG are flagged for review before the claim is paid. Therapy claim reviews were added to the Prepayment Demonstration in April 2013 (see Outpatient Therapy Reviews below).

During FY 2014, over 61% of the claims reviewed as part of the Prepayment Review Demonstration were improperly billed, which resulted in $51.8 million in savings to the Medicare Trust Funds, illustrating the importance of this demonstration. Appeals data on demonstration claims are limited at this time, as these claims have yet to proceed through multiple levels of appeals. It is not anticipated that the appeals rate will be higher than that of other Recovery Auditor claims reviewed on a postpayment basis. CMS will continue to monitor and evaluate the effectiveness of this demonstration, as well as the savings to the Medicare Trust Funds.

As part of the close-out process for the existing Recovery Auditor contracts while CMS worked to procure new contractors, the prepayment demonstration was paused. The edits that flag claims for review and trigger the ADR letter were stopped in February 2014. The demonstration continues to remain on hold while CMS assesses its options regarding the procurement of the next Recovery Auditor contracts.

Outpatient Therapy Reviews

The American Taxpayer Relief Act (ATRA) of 2012, which extended the Medicare Part B Outpatient Therapy Cap Exceptions Process through December 31, 2013, contains a number of Medicare provisions that directly impact the manual medical review threshold for outpatient therapy caps. Provisions of the Financial Limitation for Outpatient Therapy Services – Section 3005 of the Middle Class Tax Relief and Job Creation Act of 2012 required CMS to temporarily apply therapy caps and related provisions to the therapy services furnished in an outpatient hospital between the dates January 1, 2013 through December 31, 2013. The Pathway for Sustainable Growth Rate (SGR) Reform Act of 2013 extended these reviews through March 31, 2014. On April 1, 2014, President Obama signed into law the Protecting Access to Medicare Act of 2014 (PAMA). PAMA extends the exceptions process for outpatient therapy caps through March 31, 2015. Section 103 of PAMA contains a number of Medicare provisions affecting the outpatient therapy caps and manual medical review (MR) threshold.

Claims for therapy services that have exceeded the threshold for the year require complex medical review. There are two separate thresholds that trigger the medical review process:

- A $3,700 threshold for Occupational Therapy (OT) services per year, per beneficiary.
- A $3,700 combined threshold for Physical Therapy (PT) and Speech Language Pathology (SLP) services per year, per beneficiary. Note: Although PT and SLP services are combined for triggering the threshold, medical review is conducted separately by discipline.

For states involved in the prepayment review demonstration, applicable therapy claims above the threshold are flagged for review before payment. In the remaining states, these claims are paid upon claim submission, and then subject to immediate Recovery Auditor postpayment review.

The therapy cap applies to all Part B outpatient therapy settings and providers including:

- Therapists' Private Practices

- Offices of physicians and certain non-physician practitioners
- Part B Skilled Nursing Facilities
- Home Health Agencies[13]
- Rehabilitation agencies (also known as Outpatient Rehabilitation Facilities)
- Comprehensive Outpatient Rehabilitation Facilities
- Hospital Outpatient Departments
- Critical Access Hospitals[14]

[13] Outpatient therapy provided in the home, billed with Type of Bill (TOB) 34x.
[14] Therapy caps were applied to Critical Access Hospitals in calendar year 2014.

Corrective Actions

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.

CMS has established a process to implement corrective actions for program vulnerabilities based on Recovery Auditor reviews. Recovery Auditors request approval from CMS to review different types of claims. The request may be based on a particular code or group of codes, a particular setting, or a number of other factors. Recovery Auditors must post to their individual websites the areas of review for which they have been approved, prior to beginning those reviews. In FY 2014, if the same area of review was approved for each of the four Recovery Audit regions, CMS would consider them one review for the purposes of corrective actions.

Definition and Identification of Vulnerabilities

CMS analyzes all areas of review with more than $500,000 in Recovery Audit corrections and groups them into vulnerability categories. Vulnerability is defined as a claim type or series of related claim types that pose a financial risk to the Medicare FFS program due to the claim type's susceptibility to improper payments. Improper payments could be due to a lack of medical necessity, incorrect coding, or lack of documentation.

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. Providers have the right to appeal a claim that is denied by national claims processing system edits. The MACs develop edits for their local claim processing systems based on identified improper payments in their jurisdiction. Additionally, CMS develops medically unlikely edits (MUEs) that deny claims where the services billed exceed a number that would be clinically reasonable, CMS and National Correct Coding Initiative (NCCI) edits to catch those services that are coded incorrectly. Both MUEs and NCCI edits are updated quarterly.

Vulnerabilities identified through automated review may be corrected by national claims processing system edits, MUE, or NCCI edits. However, those identified through complex review generally cannot be corrected by an edit. Such claims may need to be corrected through provider education, prepayment review, postpayment review, or changes in CMS policy. Semi-automated review vulnerabilities are included in the complex category because they cannot be corrected by an edit. (Refer to page 5 for the definitions of automated, semi-automated, and complex reviews.)

Summary of FY 2014 Vulnerabilities[15]

CMS prioritizes vulnerabilities based on the dollar amount corrected, as well as the date the vulnerability was identified. In FY 2014, CMS identified 12 vulnerabilities through the Recovery Audit program.

[15] 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)*)*

Eleven of the 12 vulnerabilities were identified through automated review. One vulnerability was identified through semi-automated review. As of September 30, 2014, the Recovery Auditors corrected $2.57 billion in improper payments based on these vulnerabilities.

Corrective Actions for Automated Vulnerabilities

CMS works to address Recovery Auditor-identified automated vulnerabilities promptly to prevent future improper payments. However, some vulnerabilities identified in FY 2014 will not have claims processing edits implemented until after FY 2014. It is also possible that claims processing edits are already in place for some vulnerabilities but need to be re-evaluated for effectiveness, while other edits have been implemented more recently, but the effects of the edit have not yet been realized. CMS drafted 12 national edits in FY 2014 for topics identified in FY 2013.

National system edits are based on national coverage determinations and policies. Recovery Auditor automated vulnerabilities based on MAC LCDs require local system edits. These policies are individualized and can differ among each MAC. Although the MACs receive regular notification of all Recovery Auditor vulnerabilities, they have limited resources with which to implement their edits. Through their Medical Review Strategy (MRS) report, their ERRP, and data analysis, MACs prioritize the areas that are most susceptible to improper payments in their jurisdiction. They then focus on those areas that would benefit most from local system edits. CMS does not instruct the MACs on which system edits to implement.

Corrective Actions for Complex Vulnerabilities

Below is a summary of actions that have been taken for complex vulnerabilities that were previously identified:

- FY 2014 IPPS Final Rule (effective October 1, 2013) allows Medicare to pay for reasonable and necessary Part B hospital inpatient services when a Part A inpatient admission is denied as not reasonable and necessary. This policy also permits the hospital to bill for Part B hospital inpatient services if the hospital conducts a self-audit or other utilization review that suggests that the beneficiary should have been treated as an outpatient, rather than admitted to the hospital as an inpatient. This rule also expanded payment for Part B hospital inpatient services, which was previously limited to a subset of services known as ancillary services. The final rule confirmed that claims must be submitted within 12 months of the date of service to receive payment.

- CMS is continuing the Prior Authorization of Power Mobility Devices (PMDs) Demonstration. Since this implementation, CMS has observed a decrease in expenditures for PMDs in the demonstration states and non-demonstration states. Based on claims processed from the inception of the pilot on September 1, 2012 through July 11, 2014, monthly expenditures for the PMD codes included in the demonstration decreased from $20 million in September 2012 to $5 million in March 2014 in the non-demonstration states and from $12 million to $2 million in the demonstration states. CMS believes many national suppliers have adjusted their billing practices nationwide and are now complying with CMS policies based on their experiences with prior authorization in the demonstration states. To assist providers with submitting prior authorization requests, CMS developed data elements for an Electronic Clinical Template for PMDs. For more information, please visit the PMD Electronic Clinical Template website.

- The CERT program has completed eight Special Studies in FY 2014. CERT Special Study topics are available to providers. MACs post the topics under review on their websites. Special Studies are intended to provide information on areas which:
    - Have had historically high improper payment rates
    - Are at risk for improper payments
    - Are new Medicare covered benefits
    - Have recently been impacted by changes in policy

  CMS has issued reports on FFS facility billing practices for eight facility types in FY 2014. The Program for Evaluating Payment Patterns Electronic Report (PEPPER) is a file containing hospital-specific data statistics for target areas often associated with Medicare improper payments due to billing, MS-DRG coding and/or admission necessity issues. Target areas are determined by CMS. PEPPERs can be used to compare data statistics over time to identify changes in billing practices, pinpoint areas in need of auditing and monitoring, identify potential DRG under- or over-coding problems and identify target areas where length of stay increased. PEPPERs can assist hospitals and facilities achieve CMS' goal of reducing and preventing improper payments. For more information, please visit the PEPPER website.

- CMS has issued seven Comparative Billing Reports (CBRs) on billing practices in FY 2014. CBRs contain data-driven tables and graphs with an explanation of findings that compare providers' billing and payment patterns to those of their peers located in their state and across the nation.

  To protect privacy, CMS issues each agency CBR confidentially and provides only summary billing information. No patient or case-specific data is included. CMS believes CBRs are a tool to help providers better understand Medicare billing rules and improve the level of care for patients. The MACs post CBR topics under the review section of their websites.

- CMS has issued seven Medicare Learning Network (MLN) articles and 4 Quarterly Provider Compliance Newsletters, providing detailed information on 19 findings identified by the Medicare FFS Recovery Auditors in FY 2014. CMS has received positive feedback from provider associations regarding the value of these documents and plans to continue their issuance. For more information, these articles are available at the MLN Provider Compliance website.

  CMS contractors also post MLN Matters articles to their websites as well as other educational material relevant to CMS policy and LCDs for their jurisdictions. For more information, please review national policy guidance at the Medicare Coverage Database.

Continuous Improvement

CMS is committed to working with the Recovery Auditors, the provider and supplier communities, and other stakeholders to continuously improve the Recovery Auditor 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. All four Recovery Auditors saw participation in the esMD program increase in FY 2014. Provider participation varies across Recovery Auditors but is as high as 27 percent of all documentation submitted to Performant (Region A).[16] This esMD program promotes both efficiency and organization, while reducing provider burden and administrative costs. CMS anticipates even higher participation in FY 2015.

CMS encourages the Recovery Auditors and claims processing contractors to meet to discuss program issues and potential improvements. CMS hosts regular teleconference meetings with the Recovery Auditors that serve as a forum to focus on clinical issues, appeals, operational issues, and best practices. By nurturing contractor collaboration, CMS hopes to:

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

CMS continues to encourage Recovery Auditors to expand their review strategies to include different types of providers, including a statement of work (SOW) change that emphasizes the review of claim types with high error rates.

At times, CMS will refer issues of potential improper payments to the Recovery Auditors for their review. These referrals may come from MACs and ZPICs, or external entities such as the Office of Inspector General (OIG) and Government Accountability Office (GAO). These referrals will typically include uniform review rationale and website language, as well as standard claim selection criteria and edit parameters so that all Recovery Auditors are reviewing the claims consistently. These referrals are optional for the Recovery Auditors, and should a Recovery Auditor choose not to accept a particular issue, CMS retains the right to give those claims to a different Recovery Auditor for review. Recovery Auditors do receive an increased contingency fee on the OIG referrals that result in improper payment correction.

[16] This data is self-reported by the Recovery Auditors.

CMS regularly evaluates the Recovery Auditors' performance and adherence to the requirements in their SOWs. Staff members go on location to observe medical reviewers, Information Technology 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 CPARS for an overall performance rating for the year. These results are available to all federal agencies. CMS believes that regular contractor oversight is essential to the success of the Recovery Audit Program.

In February 2014, CMS posted a list of *Recovery Audit Program Improvements*.[17] This document listed five of the improvements that would be implemented with the awarding of the new contracts. The five improvements were:

- Recovery Auditors must wait 30 days to allow for a discussion after discovering an improper payment before sending the claim to the MAC for adjustment. Providers will not have to choose between initiating a discussion and an appeal.
- Recovery Auditors must confirm receipt of a discussion request within three days.
- Recovery Auditors must wait until the second level of appeal is exhausted before they receive the contingency fee.
- CMS is establishing revised ADR limits that will be diversified across different claim types (e.g., inpatient, outpatient claims).
- CMS will require Recovery Auditors to adjust the ADR limits in accordance with a provider's denial rate. Providers with low denial rates will have lower ADR limits while provider with high denial rates will have higher ADR limits.

Additional improvements will be added to this document after the first new contract is awarded. The improvements will address the three key areas of success for the program: Reducing Provider Burden, Enhancing CMS Oversight and Review Accuracy, and Increasing Program Transparency.

[17] This document is available at the Recovery Audit Program website.

Program Development

OIG Oversight

In September 2013, the OIG issued a report on Medicare Recovery Audit Contractors and CMS's Actions to Address Improper Payments, Referrals of Potential Fraud, and Performance, OEI-04-11-00680. The report focused on the extent the FFS Recovery Auditors identified improper payments and the corrective actions CMS took to address those payment vulnerabilities. The OIG also examined the extent to which the Recovery Auditors referred suspected fraud to CMS and the actions CMS took on those referrals. Finally, OIG reviewed the extent that the Recovery Auditors' performance evaluations addressed performance metrics and contract requirements.

The OIG found that CMS took action to address the majority of vulnerabilities identified but did not assess the effectiveness of these actions; CMS did not take action to address six referrals of potential fraud; CMS' performance evaluations did not include metrics to evaluate the contractors on all contract requirements.

The OIG recommended that CMS take action on vulnerabilities that are pending corrective action and determine the effectiveness of implemented corrective actions. CMS concurred with this recommendation and considers the vulnerabilities that were pending corrective action at the time of the OIG's audit to be closed. CMS agrees that determining the effectiveness of corrective actions is important and continues to explore the feasibility of developing a protocol that attempts to quantify the effectiveness of corrective actions using a combination of tools including data analysis, error rate measurement, continued identification of overpayments via post payment review, and other factors.

The OIG also recommended that CMS increase the Recovery Auditors' referral of potential fraud. CMS agreed and facilitates increased collaboration between Recovery Auditors, CMS and program integrity contractors. Pursuant to the Office of Financial Management's (OFM) Memorandum of Understanding (MOU) with the OIG, CMS will continue to instruct the Recovery Auditors to concurrently refer all instances of suspected fraud both to the OIG and CMS. The OIG recommended that CMS take action on the six instances of suspected fraud that the Recovery Auditors referred to CMS. CMS did review these in concert with the applicable ZPIC/Program Safeguard Contractor (PSC). One referral resulted in revoking Medicare billing privileges from that provider.

In addition, the OIG recommended that CMS develop additional performance evaluation metrics to improve Recovery Auditor performance and to evaluate them on contract requirements. CMS concurred that performance metrics, such as accuracy and appeal targets, are important measures and should be a part of the regular performance evaluations. CMS revised the latest CPARS evaluations to incorporate metrics on the Recovery Auditors' identification of improper payments and accuracy rates. CMS does not believe it is appropriate to include other metrics, such as quotas for fraud referrals, as that is not a major task of these contracts. CMS also revised the new SOW to add a metric based on the number of overpayment determinations overturned at the first level of appeal, as well as other relevant performance measures.

GAO Oversight

On July 23, 2013, the GAO issued "Increasing Consistency of Contractor Requirements May Improve Administrative Efficiency" (GAO 13-522). This report states that postpayment review contractors such as Recovery Auditors, as well as MACs, ZPICs, and the CERT review contractor differ regarding requirements for claims reviews, assesses the extent to which requirements for postpayment claims reviews differ across contractors, and whether the differences, if any, could impede effective and efficient claims reviews.

The GAO recommended that CMS examine all postpayment review requirements for contractors to determine those that could be made more consistent without negatively impacting program integrity; communicate publicly CMS' findings and time frame for taking further action; and reduce differences in postpayment review requirements where it can be done without impeding the efficiency of efforts to reduce improper payments. The GAO specifically noted that CMS asserts more controls over the Recovery Auditors than other contractor types, including control over ADR limits, the review approval process, posting review issues on websites, reimbursing certain providers for medical records, and offering a discussion period. CMS agreed with the GAO's recommendations and started taking steps toward more contractor consistency. In the Recovery Auditor SOWs for the next round of contracts, CMS removed the prohibition for the Recovery Auditors to deny claims for minor omissions, such as an illegible signature. CMS has also reduced the number of days the Recovery Auditor has to review the documentation submitted by providers to 30 days.[18]

[18] Available at the Recovery Audit Program website.

Appendices

A. Social Security Act (Section 1893(h))

B. Amount Returned to the Medicare Trust Funds (table)

C. Corrections by State (table)

D. Corrections by Type of Claim
- D1. Corrections by Type of Claim (table)
- D2. Overall FFS Medicare Benefits (table)

E. Corrections by Provider Type
- E1. Corrections by Provider Type (table)
- E2. Total Medicare Benefit Payments by Provider Type (table)

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

G. Overpayments by Provider Type
- G1. Overpayments by Provider Type (figure)
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Appendix A:

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 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.

(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 B: Amount Returned to the Medicare Trust Funds (in Millions)

Overpay-ments Collected	-	Underpay-ments Restored	-	Amount Over-turned on Appeal[19]	-	Recovery Auditor Contin-gency Fees	-	CMS Admini-stration Costs	=	Amount Returned to Medicare Trust Funds
$2,394.8		**$173.1**		**$157.4**		**$274.6**		**$186.3**		**$1,603.4**

Note: CMS administration costs include adjusting claims, processing appeals, supporting contractors, and CMS full time equivalents.

[19] This includes only those appeals overturned at the first level.

Appendix C: FY 2014 Corrections by State

State	Collected Overpayments	Restored Underpayments	Total Corrected Amount
AK	$5,752,377.68	$261,001.80	$6,013,379.48
AL	$41,562,836.58	$9,955,130.77	$51,517,967.35
AR	$57,322,622.13	$1,942,996.79	$59,265,618.92
AS	$601.24	-	$601.24
AZ	$53,735,701.69	$1,635,456.51	$55,371,158.20
CA	$261,036,006.34	$11,895,504.44	$272,931,510.78
CO	$49,302,869.91	$2,637,788.76	$51,940,658.67
CT	$36,389,637.02	$342,389.01	$36,732,026.03
DC	$13,529,584.27	$113,731.12	$13,643,315.39
DE	$8,943,090.56	$82,229.95	$9,025,320.51
FL	$138,801,665.00	$12,185,832.75	$150,987,497.75
GA	$56,810,140.75	$9,941,677.09	$66,751,817.84
GU	$95,504.50	$82.94	$95,587.44
HI	$4,996,510.89	$273,346.90	$5,269,857.79
IA	$24,468,196.04	$483,318.54	$24,951,514.58
ID	$2,311,133.15	$252,721.56	$2,563,854.71
IL	$80,828,116.39	$3,257,735.14	$84,085,851.53
IN	$53,188,096.66	$3,780,835.01	$56,968,931.67
KS	$25,528,074.98	$630,006.66	$26,158,081.64
KY	$48,040,219.23	$2,808,951.84	$50,849,171.07
LA	$59,028,221.29	$2,788,533.63	$61,816,754.92
MA	$21,575,672.47	$2,868,921.83	$24,444,594.30
MD	$16,057,100.87	$225,668.60	$16,282,769.47
ME	$3,294,385.21	$384,826.86	$3,679,212.07
MI	$62,960,416.49	$2,830,997.43	$65,791,413.92
MN	$4,958,717.77	$1,192,638.21	$6,151,355.98
MO	$32,502,691.79	$1,258,166.87	$33,760,858.66
MP	$1,689.96	-	$1,689.96
MS	$55,048,689.18	$3,045,026.11	$58,093,715.29
MT	$10,847,777.43	$180,380.03	$11,028,157.46
NC	$82,542,072.70	$7,772,455.91	$90,314,528.61
ND	$11,408,680.70	$150,016.88	$11,558,697.58
NE	$12,602,952.26	$194,111.21	$12,797,063.47
NH	$2,509,555.16	$449,603.81	$2,959,158.97
NJ	$66,943,648.87	$1,081,331.02	$68,024,979.89
NM	$23,750,295.24	$1,388,669.35	$25,138,964.59
NV	$14,583,805.30	$614,058.45	$15,197,863.75
NY	$129,887,254.47	$1,053,353.04	$130,940,607.51

State	Collected Overpayments	Restored Underpayments	Total Corrected Amount
OH	$82,415,572.48	$5,671,998.47	$88,087,570.95
OK	$58,310,837.08	$2,938,017.90	$61,248,854.98
OR	$6,944,080.76	$1,050,891.17	$7,994,971.93
PA	$95,890,222.61	$1,522,524.44	$97,412,747.05
PR	$236,806.00	$252.96	$237,058.96
RI	$2,040,498.14	$335,742.48	$2,376,240.62
SC	$43,690,924.29	$1,759,851.79	$45,450,776.08
SD	$10,839,220.78	$163,760.71	$11,002,981.49
TN	$53,807,743.24	$7,493,937.37	$61,301,680.61
TX	$237,176,874.47	$14,233,158.78	$251,410,033.25
UT	$14,681,456.88	$294,213.77	$14,975,670.65
VA	$67,900,155.49	$6,102,621.86	$74,002,777.35
VI	$251,975.71	$546.24	$252,521.95
VT	$913,447.10	$186,937.98	$1,100,385.08
WA	$20,593,043.24	$1,535,155.01	$22,128,198.25
WI	$6,840,846.13	$1,587,853.10	$8,428,699.23
WV	$19,377,607.65	$1,213,726.49	$20,591,334.14
WY	$5,349,945.90	$66,526.00	$5,416,471.90
Unknown	$94,438,280.13	$36,979,690.42	$131,417,970.55
Total	***$2,394,846,150.25***	***$173,096,903.76***	***$2,567,943,054.01***

Appendix D1: FY 2014 Corrections by Type of Claim

	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	578,775	$2,305,449,726	68,982	$171,120,871	647,757	$2,476,570,597
Part B	313,107	$44,825,908	8,683	$1,905,641	321,790	$46,731,550
DME	147,415	$44,570,516	95	$70,392	147,510	$44,640,907
Total	***1,039,297***	***$2,394,846,150***	***77,760***	***$173,096,904***	***1,117,057***	***$2,567,943,054***

Appendix D2: FY 2014 Overall FFS Medicare Benefit Payments (in Billions)

Benefit Type	Expenditures
Part A	190.0
Part B	168.1
DME	6.4
Total	***364.5***

Note: Total excludes Managed Care and Part D expenditures.

Source: CMS Office of the Actuary

Appendix E1: FY 2014 Corrections by Provider Type

Claim Type	Overpayments Collected	Underpayments Restored	Total Amount Corrected
Inpatient	$2,017,224,862	$93,217,990	$2,110,442,852
SNF	$85,832,159	$151,314	$85,983,472
Hospice	-	-	-
Outpatient	$78,682,268	$36,512,554	$115,194,822
Home Health	$30,020,412	$4,878,032	$34,898,444
Physician	$44,192,452	$1,286,931	$45,479,383
DME	$44,457,316	$70,392	$44,527,708
Other	$94,438,280	$36,979,690	$131,417,971
Total	***$2,394,847,749***	***$173,096,903***	***$2,567,944,652***

Appendix E2: FY 2014 Total Medicare Benefit Payments by Provider Type

Claim Type	Total Benefit Payments (in millions)
Inpatient	136,141
SNF	30,141
Hospice	16,830
Outpatient	40,204
Home Health	18,352
Physician/other suppliers	71,079
DME	6,427
Other	45,373
Total	***364,547***

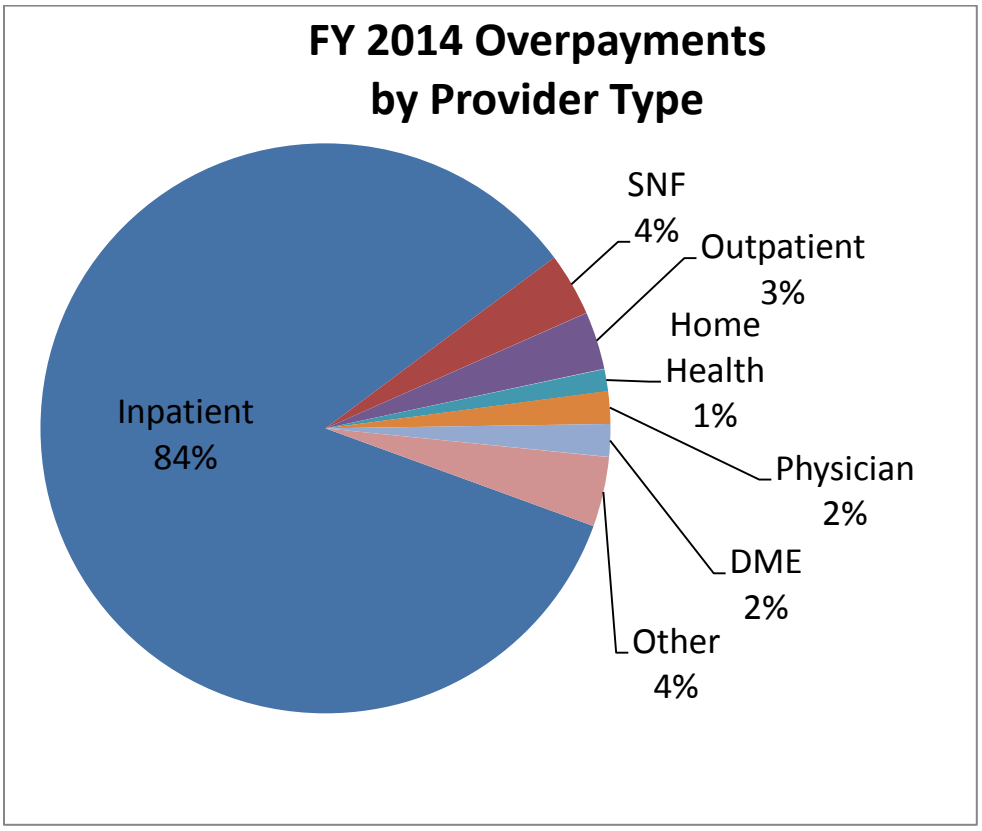
Note: Total excludes Managed Care and Part D expenditures.

Source: CMS, Office of the Actuary

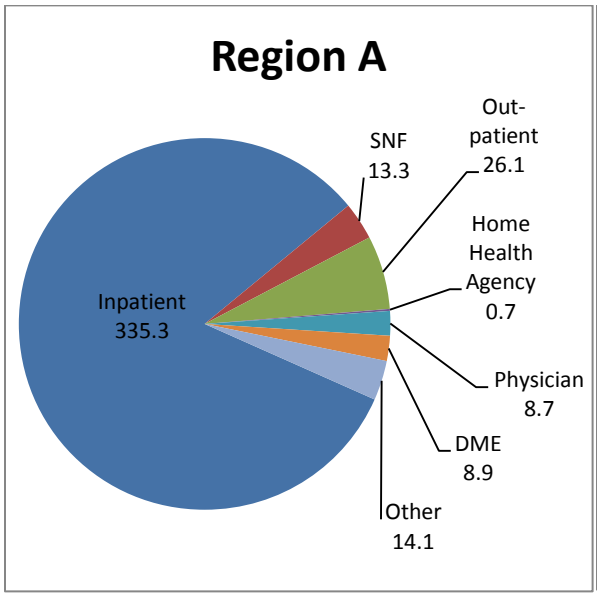
Appendix F: FY 2014 Corrections by Recovery Auditor and Type of Claim

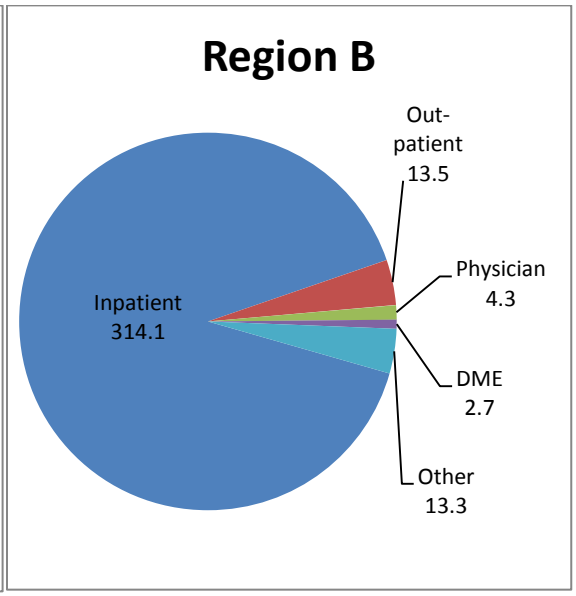
		Overpayments Collected		Underpayments Restored		Total Corrected	
Recovery Auditor	**Claim Type**	**No. of Claims**	**Amount Collected**	**No. of Claims**	**Amount Restored**	**No. of Claims**	**Amount Corrected**
	A	76,373	$389,283,263	3,057	$11,317,761	79,430	$400,601,024
	B	28,644	$8,916,449	108	$42,146	28,752	$8,958,595
	DME	17,836	$8,902,467	95	$70,392	17,931	$8,972,858
Performant	*Subtotal*	*122,853*	*$407,102,179*	*3,260*	*$11,430,299*	*126,113*	*$418,532,477*
	A	85,106	$340,709,649	14,602	$34,450,001	99,708	$375,159,650
	B	27,105	$4,385,553	924	$66,024	28,029	$4,451,577
	DME	37,509	$2,746,761	-	-	37,509	$2,746,761
CGI	*Subtotal*	*149,720*	*$347,841,963*	*15,526*	*$34,516,025*	*165,246*	*$382,357,988*
	A	273,231	$1,093,089,925	39,894	$95,771,692	313,125	$1,188,861,617
	B	86,894	$16,235,877	2,653	$1,247,670	89,547	$17,483,546
	DME	41,088	$21,525,448	-	-	41,088	$21,525,448
Connolly	*Subtotal*	*401,213*	*$1,130,851,250*	*42,547*	*$97,019,362*	*443,760*	*$1,227,870,611*
	A	140,442	$477,762,662	9,614	$26,161,330	150,056	$503,923,992
	B	170,464	$15,288,030	4,998	$549,802	175,462	$15,837,832
	DME	50,982	$11,395,840	-	-	50,982	$11,395,840
HDI	*Subtotal*	*361,888*	*$504,446,532*	*14,612*	*$26,711,132*	*376,500*	*$531,157,664*
	A	3,623	$4,604,228	1,815	$3,420,086	5,438	$8,024,314
	B	-	-	-	-	-	-
Unknown	*Subtotal*	*3,623*	*$4,604,228*	*1,815*	*$3,420,086*	*5,438*	*$8,024,314*
Total		***1,039,297***	***$2,394,846,152***	***77,760***	***$173,096,904***	***1,117,057***	***$2,567,943,054***

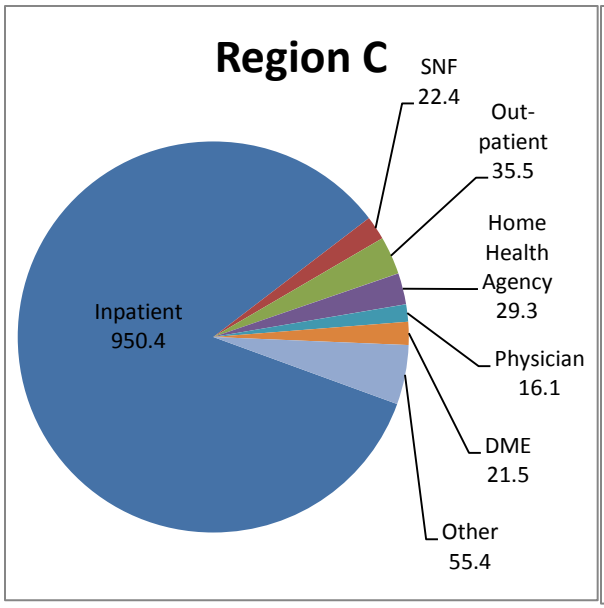
Appendix G1: FY 2014 Overpayments by Provider Type

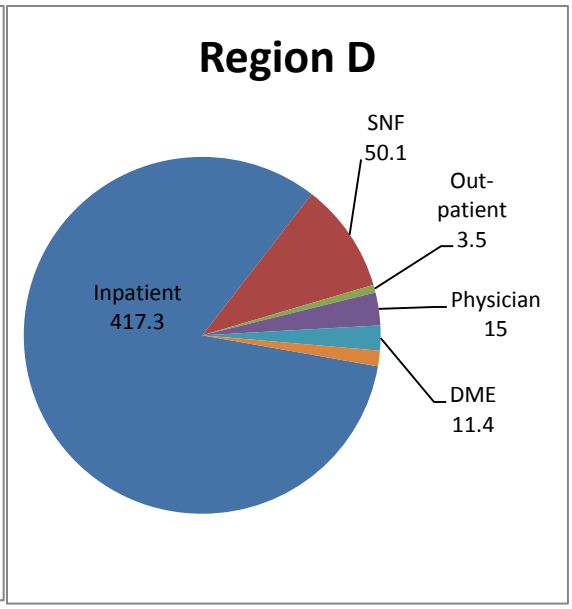


Appendix G2: FY 2014 Overpayments by Provider Type and Recovery Auditor (in millions of dollars)





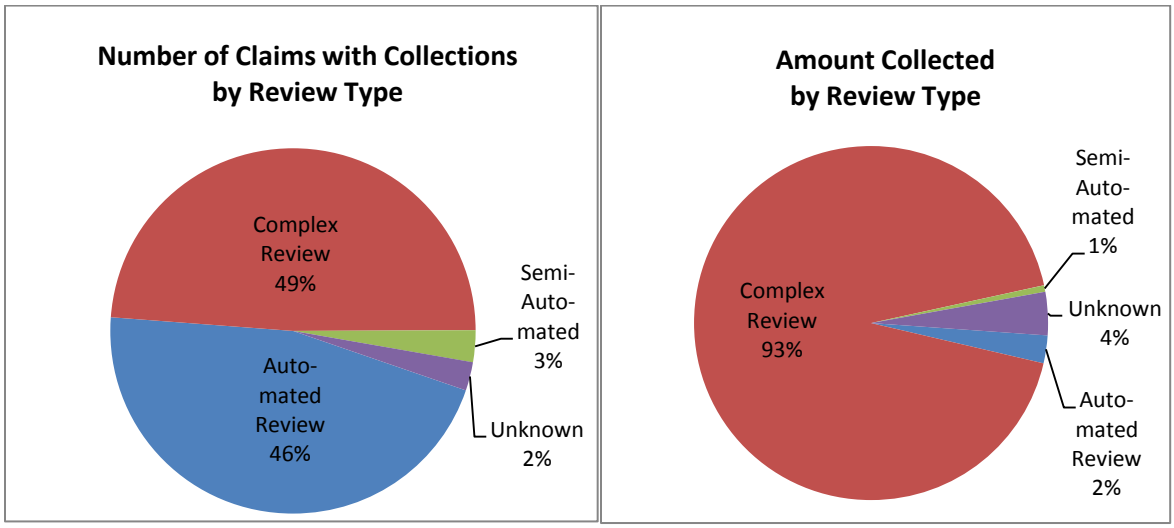




Appendix H1: FY 2014 Corrections by Review Type

	Overpayments Collected		Underpayments Restored		Total Corrected	
Review Type	**No. of Claims**	**Amount Collected**	**No. of Claims**	**Amount Restored**	**No. of Claims**	**Amount Corrected**
Automated	477,123	$60,573,148	22,193	$35,790,603	499,316	$96,363,752
Complex	506,715	$2,225,700,473	30,429	$100,209,498	537,144	$2,325,909,972
Semi-Automated	29,147	$14,134,248	44	$117,112	29,191	$14,251,360
Unknown[20]	26,312	$94,438,280	25,094	$36,979,690	51,406	$131,417,971
Total	***1,039,297***	***$2,394,846,149***	***77,760***	***$173,096,903***	***1,117,057***	***$2,567,943,055***

Appendix H2: FY 2014 Collections by Review Type



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

Appendix H3: FY 2014 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**
Performant	Auto	41,863	$8,783,697	173	$5,211	42,036	$8,788,908
	Complex	74,507	$380,298,720	1,743	$8,405,234	76,250	$388,703,954
	Semi-Auto	2,730	$3,918,155	4	$971	2,734	$3,919,126
	Unknown	3,753	$14,101,607	1,340	$3,018,883	5,093	$17,120,490
	Subtotal	*122,853*	*$407,102,179*	*3,260*	*$11,430,299*	*126,113*	*$418,532,477*
CGI	Auto	63,925	$7,767,297	5,428	$15,799,919	69,353	$23,567,216
	Complex	80,557	$326,553,660	1,454	$4,993,354	82,011	$331,547,015
	Semi-Auto	1,017	$253,647	7	$3,778	1,024	$257,424
	Unknown	4,221	$13,267,359	8,637	$13,718,975	12,858	$26,986,334
	Subtotal	*149,720*	*$347,841,963*	*15,526*	*$34,516,025*	*165,246*	*$382,357,988*
Connolly	Auto	146,263	$22,756,404	11,645	$6,102,982	157,908	$28,859,386
	Complex	233,092	$1,045,422,490	25,554	$80,374,139	258,646	$1,125,796,629
	Semi-Auto	11,341	$7,279,122	16	$42,040	11,357	$7,321,162
	Unknown	10,517	$55,393,233	5,332	$10,500,201	15,849	$65,893,434
	Subtotal	*401,213*	*$1,130,851,250*	*42,547*	*$97,019,362*	*443,760*	*$1,227,870,611*
HDI	Auto	225,072	$21,265,750	4,947	$13,882,492	230,019	$35,148,242
	Complex	118,559	$473,425,603	1,678	$6,436,771	120,237	$479,862,374
	Semi-Auto	14,059	$2,683,325	17	$70,323	14,076	$2,753,648
	Unknown	4,198	$7,071,853	7,970	$6,321,546	12,168	$13,393,399
	Subtotal	*361,888*	*$504,446,531*	*14,612*	*$26,711,132*	*376,500*	*$531,157,663*
Unknown[21]	Unknown	*3,623*	$4,604,228	*1,815*	$3,420,086	5,438	$8,024,314
Total		***1,039,297***	***$2,394,846,150***	***77,760***	***$173,096,904***	***1,117,057***	***$2,567,943,054***

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

Appendix I: FY 2014 Complex Review Improper Payment Identification Rate

Recovery Auditor	Number of ADRs Fulfilled by Providers	Improper Payment Identifications*	Improper Payment Identification Rate
Performant	102,726	30,499	29.7%
CGI	69,016	24,412	35.4%
Connolly	119,317	55.937	46.9%
HDI	42,750	18,633	43.6%
Total/Average	***333,809***[22]	***258,962***	***38.9%***

*Identifications include claims with demanded overpayments and underpayments

[22] 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. This chart does not include those technical denials based on non-receipt of documentation.

Appendix J: FY 2014 Cumulative Accuracy Scores

Recovery Auditor	Accuracy Score
Performant	96.4%
CGI	91.5%
Connolly	98.7%
HDI	98.6%

Note: In FY 2014, 12 random samples from each Recovery Auditor were drawn to determine the accuracy scores. The universe for each region was all claims adjusted by the Recovery Auditor from August 2013 – July 2014. The sample size reviewed for each Recovery Auditor was between 1,156 and 1,198 claims.

Appendix K1: FY 2014 Recovery Audit Program Appeals by Claim Type – Level 1 (MAC)

Claim Type	Claims with Overpayment Determinations	Appealed Claims Decided	% of Overpayment Determinations Appealed	Appealed Claims Withdrawn/ Dismissed		Decided Claims Overturned	
				#	%	#	%
Part A	343,430	299,476	87.2%	4,694	1.6%	34,933	11.7%
Part B/DME	386,696	132,599	34.3%	10,926	8.2%	65,670	49.5%
Total	730,126	432,075	59.2%	15,620	3.6%	100,603	23.3%

Source: CMS CROWD System and Medicare Appeals System

Appendix K2: FY 2014 Recovery Audit Program Appeals by Claim Type – Level 2 (QIC)

Claim Type	Appealed Claims Decided	Appealed Claims Withdrawn/ Dismissed		Decided Claims Overturned	
		#	%	#	%
Part A	328,857	1,746	0.5%	68,465	20.8%
Part B/DME	8,391	234	2.8%	1,367	16.3%
Total	337,248	1,980	0.6%	69,832	20.7%

Source: AdQIC (Q2A Administrators)

Appendix K3: FY 2014 Recovery Audit Program Appeals by Claim Type – Level 3 (ALJ)

Claim Type	Appealed Claims Decided	Appealed Claims Withdrawn/ Dismissed*		Appealed Claims Remanded to QIC		Decided Claims Overturned**	
		#	%	#	%	#	%
Part A	28,627	6,967	24.3%	533	1.9%	12,235	42.7%
Part B (incl. DME***)	712	418	58.7%	4	0.6%	181	25.4%
Total	29,339	7,385	25.2%	537	1.8%	12,416	42.3%

Source: OMHA
Data Run: August 11, 2015
*Includes all dismissed claims, including those withdrawn by the appellant
**Includes fully favorable and partially favorable claims

***Includes claims in DME, Orthotics/Prosthetics, and Medical Supplies categories
Claims with dispositions of Escalated, Expedited Access to Judicial Review, Removal to MAC/DAB, and No Disposition were excluded.

Appendix K4: FY 2014 Recovery Audit Program Appeals by Claim Type – Level 4 (DAB)

Claim Type	Appealed Claims Decided	Appealed Claims Withdrawn/ Dismissed		Appealed Claims Remanded to ALJs		Decided Claims Overturned	
		#	%	#	%	#	%
Part A	376	142	37.8%	126	33.5%	5	1.3%
Part B/DME	103	5	4.9%	3	2.9%	0	0.0%
Total	479	147	30.7%	129	26.9%	5	1.0%

Source: AdQIC (Q2A Administrators)

Appendix K5: FY 2014 Total Recovery Audit Program Appeal Decisions by Claim Type – All Levels

Claim Type	Total Appeal Decisions	Total Overturn Decisions[23]	
		#	%
Part A	657,336	115,638	17.6%
Part B/DME	141,805	67,218	47.4%
Total	799,141	182,856	22.9%

Note: The statistics above include first, second, third, and fourth level appeal decisions in FY 2014. Appealed claims may be counted multiple times if the claim had multiple appeal decisions rendered during FY 2014. For example, if a claim was appealed to the first level and received a decision in FY 2014, then appealed to the second level and received a decision in FY 2014, both decisions would be counted in the totals above. Claims may have overpayment determination dates prior to FY 2014.

[23] Includes overturn decisions at all levels of appeal during FY 2014.

Appendix L: Recovery Audit Program Informational Resources

Website	Information Provided
go.cms.gov/RAC	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, quarterly updates on corrections and identified vulnerabilities, articles for provider education, and other program updates.
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/rac* 4)Region D/HDI: *healthdatainsights.com/rac*