Payment Integrity Scorecard

Program or Activity
Centers for Medicare & Medicaid Services (CMS) Medicare Fee-for-Service (FFS)

Reporting Period
Q2 2023

FY 2022 Overpayment Amount ($M)* **$30,678**

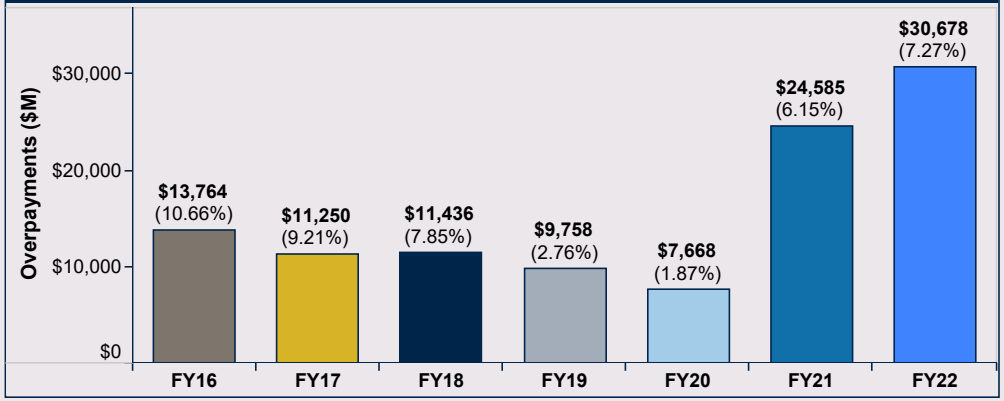
*Estimate based a sampling time frame starting 7/2020 and ending 6/2021

HHS
Centers for Medicare & Medicaid Services (CMS) Medicare Fee-for-Service (FFS)

Brief Program Description & summary of overpayment causes and barriers to prevention:

Medicare Fee-for-Service (FFS) is a federal health insurance program that provides hospital insurance (Part A) and supplementary medical insurance (Part B) to eligible citizens. The primary causes of overpayments continue to be insufficient documentation and medical necessity errors for skilled nursing facilities, hospital outpatient, hospice, and home health claims. Provider/supplier non-compliance with requirements is outside of the agency's control.

Historical Payment Rate and Amount ($M)
(Overpayment as Percentage of Total Outlays)



Discussion of Actions Taken in the Preceding Quarter and Actions Planned in the Following Quarter to Prevent Overpayments

In Quarter 2, CMS implemented a voluntary prior authorization process for Power Mobility Device Accessories with a Power Mobility Device Base. CMS' Recovery Audit Contractors continued to review inpatient claims for medical necessity and coding purposes, and the Recovery Audit Contractor Region 2 was awarded a contract allowing for the continued identification of improper payments. CMS' Supplemental Medical Review Contractor was also assigned medical reviews based on recommendations from the Office of the Inspector General. In Quarter 3, we anticipate completing development of a demonstration project to test the use of prior authorization for inpatient rehabilitation services and corrective actions to reduce the improper payment rate for hospice.

	Accomplishments in Reducing Overpayment	Date
1	Added 10 orthoses to the Master List for items that will require a face-to-face encounter and written order prior to delivery as a condition of payment.	Jan-23
2	Awarded the Recovery Audit Contractor Region 2 contract allowing for the continued identification of improper payments.	Mar-23
3	Implemented a voluntary prior authorization process for Power Mobility Device Accessories with a Power Mobility Device Base.	Mar-23

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	Goals towards Reducing Overpayments	Status	ECD
1	Develop corrective actions to reduce the improper payment rate for hospice, which was a driver for overpayments in FY 2022.	On-Track	Jun-23
2	Review Choice Demonstration for Inpatient Rehabilitation Services. Develop a demonstration project to test the use of prior authorization for inpatient rehabilitation services.	On-Track	Jun-23

	Recovery Method	Brief Description of Plans to Recover Overpayments	Brief Description of Actions Taken to Recover Overpayments
1	**Recovery Audit**	Medicare Administrative Contractors and Recovery Audit Contractors will complete post payment review and Targeted Probe and Educate based on improper payment findings.	Recovery Audit Contractors reviewed inpatient claims for medical necessity and coding purposes.
2	**Recovery Activity**	Assign review projects to the Supplemental Medical Review Contractor based on improper payment findings. The contractor will review several projects in FY 23 based on FY 22 improper payment findings and OIG report recommendations.	Assigned the Supplemental Medical Review Contractor with medical reviews based on recommendations from the Office of the Inspector General.
3	**Recovery Activity**	Use a comprehensive approach to prevent overpayments through proactive measures. National prior authorization programs are considered part of the overall recovery strategy, reducing or eliminating the need for recovery activities.	Used the Targeted Probe and Educate medical review process to review and correct overpayments and educate providers to prevent future errors.

Amt($)	Root Cause of Overpayment	Root Cause Description	Mitigation Strategy	Brief Description of Mitigation Strategy and Anticipated Impact
$30,678M	Overpayments outside the agency control that occurred because of a Failure to Access Data/Information Needed.	The primary causes of Medicare Fee-for-Service overpayments continue to be insufficient documentation and medical necessity errors for hospital outpatient, skilled nursing facility, home health, and hospice claims.	Training – teaching a particular skill or type of behavior; refreshing on the proper processing methods.	Training and education will reduce errors made when billing claims and documenting medical records. System edits, integrated medical review approaches, improved policy, and expanded provider education are used to identify and provide necessary training.