Payment Integrity Scorecard

Program or Activity	Reporting Period
Centers for Medicare & Medicaid Services (CMS) Medicare Fee-for-Service (FFS)	Q4 2023

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

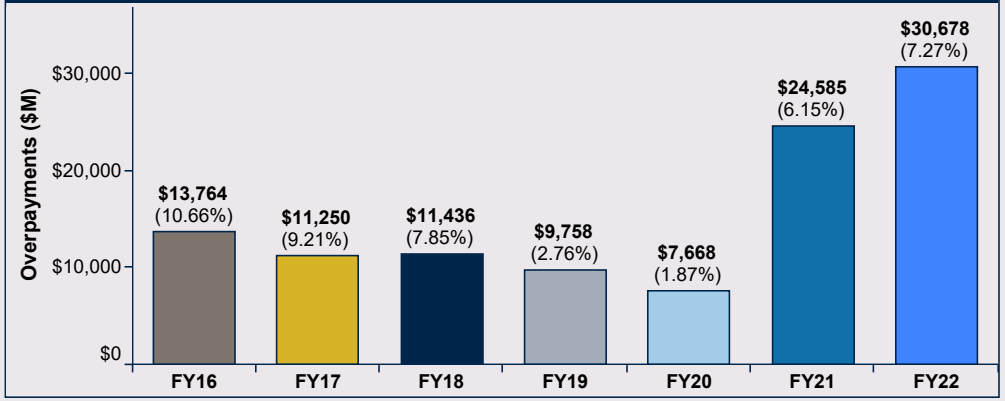
*Estimate based a sampling time frame starting 7/2020 and ending 6/2021

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. A known barrier to preventing improper payments is that providers' and suppliers' 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 4, CMS implemented the Review Choice Demonstration for Inpatient Rehabilitation Services (IRF) in Alabama. This demonstration will test the use of prior authorization in an IRF setting and its impact on the identification of possible fraud, waste, and abuse, which includes improper payments. Recovery Audit Contractors continued to review inpatient claims for medical necessity and coding purposes. The Supplemental Medical Review Contractor was also assigned medical reviews based on recommendations from the Office of Inspector General. CMS also implemented a process to reduce the improper payment rate for hospice by performing Targeted Probe and Education reviews for new hospice providers in 4 states (AZ, CA, NV, TX) that have seen significant increases in hospice enrollment.

	Accomplishments in Reducing Overpayment	Date
1	Implemented a process to complete Targeted Probe and Education reviews for new hospice providers in 4 states (AZ, CA, NV, TX) that have seen significant increases in hospice enrollment.	Jul-23
2	Implemented the Review Choice Demonstration for Inpatient Rehabilitation Facilities (IRF) in Alabama on August 21, 2023. Continued education of IRF providers in Alabama and continued working with the Medicare Administrative Contractor to ensure a smooth rollout.	Aug-23
3	Published data on Prior Authorization and Pre-Claim Review, featuring metrics like Affirmed Requests, Medicare Administrative Contractor review duration, appeals count, and accuracy rates for services with prior authorization.	Sep-23

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	Goals towards Reducing Overpayments	Status	ECD
1	Continue the Supplemental Medical Review Contractor study on hospice claims after the first 90 day election period. This study will review the beneficiary stay during the second election period to determine adherence to the eligibility requirements as well as all other coverage/payment requirements. This small study will help CMS determine if this earlier review would be beneficial to other review contractors on a larger scale.	On-Track	Mar-24
2	Complete a pilot to determine if increased interoperability using Fast Healthcare Interoperability Resources will allow for better documentation to be shared with suppliers from the ordering physician. The receipt of better documentation without significantly increasing physician burden should reduce denials and improper payments that are denied because of lack of documentation from the ordering physician.	On-Track	Jun-24

	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.	Medicare Administrative Contractors and Recovery Audit Contractors review claims, identify and collect improper payments, and provide education to providers.
2	**Recovery Activity**	Assign review projects to the Supplemental Medical Review Contractor based on improper payment findings. The contractor will complete reviews to identify improper payments for collection based on FY 23 findings and the Office of the Inspector General report recommendations.	Assigned the Supplemental Medical Review Contractor with medical reviews based on recommendations form the Office of the Inspector General. Claims are reviewed to identify improper payments for collection.
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.	Change Process – altering or updating a process or policy to prevent or correct error.	CMS prevents overpayments through prior authorization programs. Under prior authorization, the provider submits a prior authorization request to CMS and receives the decision regarding whether CMS will pay for a service before any services are rendered.
			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.
			Audit - process for assuring an organization's objectives of operational effectiveness, efficiency, reliable financial reporting, and compliance with laws, regulations, and policies.	The Supplemental Medical Review Contractor performed medical reviews of hospice, skilled nursing facility, inpatient rehabilitation facility, and durable medical equipment claims to identify improper payments for collection.