Payment Integrity Scorecard

Program or Activity	Reporting Period	FY 2023 Overpayment Amount ($M)*	$30,213
Centers for Medicare & Medicaid Services (CMS) Medicare Fee-for-Service (FFS)	Q2 2024		

*Estimate based a sampling time frame starting 7/2021 and ending 6/2022

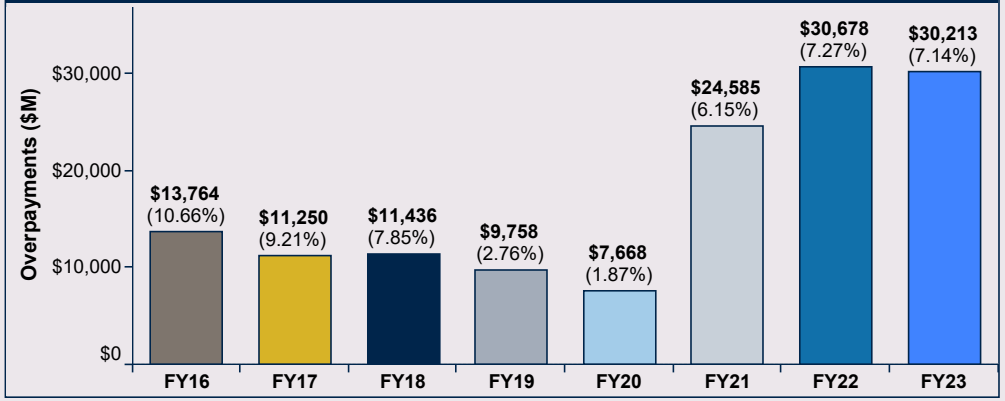
Department of Health and Human Services

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 2 of FY 2024, CMS announced the expansion of the Review Choice Demonstration for Inpatient Rehabilitation Facility Services into Pennsylvania, and continued work with stakeholders to develop a clinical template, electronic and paper, that could be used as part of the documentation requirements for home oxygen. CMS also hosted a Provider Compliance Focus Group educating providers on the documentation requirements for the various Medicare FFS prior authorization programs and the new skilled nursing facility and hospice medical review programs that began in 2023. In Quarter 3 of FY 2024, CMS plans to complete a pilot to determine if increased interoperability using fast healthcare interoperability resources will allow for better documentation to be shared with suppliers from ordering physicians and continue the Supplemental Medical Review Contractor study on hospice claims after the first 90 day election period.

	Accomplishments in Reducing Overpayment	Date
1	Completed the Supplemental Medical Review Contractor special project on the review of the hospice election medical necessity after the first 90 day election period.	Feb-24
2	Announced the expansion of the Review Choice Demonstration for Inpatient Rehabilitation Facility Services into Pennsylvania which will require Inpatient Rehabilitation Facility providers to choose pre-claim review or post payment review of all claims.	Mar-24
3	Continued work with stakeholders to develop a clinical template, electronic and paper, that could be used as part of the documentation requirements for home oxygen. A template could simplify the documentation requirements and reduce improper payments.	Mar-24

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

Reporting Period
Q2 2024

	Goals towards Reducing Overpayments	Status	ECD
1	Review and analyze the Supplemental Medical Review Contractor study on hospice claims after the first 90 day election period. This study reviewed the beneficiary stay during the second election period to determine adherence to the eligibility requirements as well as all other coverage/payment requirements. Now that it is complete, CMS will review and analyze the results to help determine if this earlier review would be beneficial to other review contractors on a larger scale.	On-Track	Jun-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 ordering physicians. 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 ordering physicians.	On-Track	Sep-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 FY2023 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
$30,213M	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.
			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.
			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.